The London School of Economics and Political Science

Throwing therapy at the problem

Mental health and humanitarian intervention in Palabek refugee settlement, northern Uganda

Costanza Torre

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Declaration

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I confirm that Chapter 9 was jointly co-authored with Dr. Elizabeth Storer, and I contributed 50% of this work.

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Abstract

This thesis examines the social, moral, and political lives of humanitarian mental health interventions in a refugee settlement in Uganda. It is written at the junction of two increasingly significant trends: the search for durable solutions for mass displacement, and the establishment of the field of global mental health as a key actor in the management of psychological suffering across the Global South. Through a scalar structure, it interrogates the intersections of psychological programmes with socio-economic conditions of chronic poverty and food insecurity, from policy discourses to refugees' phenomenological experiences of suffering. In so doing, it critically examines the political significance and therapeutic potential of mental health interventions in extremely resource-poor contexts.

Global mental health scholars and practitioners have developed approaches to refugee mental health based on three assumptions: that refugees' emotional distress should be tackled by purely psychological interventions; that these programmes are clinically significant and politically neutral; and that the 'contextual' factors that should be considered in their implementation mostly concern 'local' interpretations of mental health and illness which diverge from Western biomedical frameworks. By ethnographically exploring experiences of psychological suffering among South Sudanese – and particularly Acholi – refugees in the settlement of Palabek, northern Uganda, this thesis disputes these contentions. Based on fourteen months of in-depth ethnographic fieldwork, this thesis puts forward a critique of global mental health and humanitarian interventions that takes seriously the role of poverty and power in shaping refugees' afflictions.

This thesis shows that forms of suffering experienced by refugees in Uganda are closely linked to the structural constraints of life in displacement. It shows how these interventions intersect with refugees' phenomenological experiences of temporality and moral personhood. In so doing it argues that, when divorced from direct engagement with forms of structural injustice, current global mental health approaches actively 'do harm' by contributing to refugees' psychological afflictions. Finally, this thesis proposes new directions for refugee and global mental health; it argues for a 'temporal turn' in refugee mental health which foregrounds refugees' moral agency, and for the central role of livelihood interventions in generating therapeutic outcomes.

Abbreviations

AM	Amitriptyline
CBT	Cognitive-Behavioural Therapy
CPA	Comprehensive Peace Agreement
CPZ	Chlorpromazine
CRRF	Comprehensive Refugee Response Framework
DSM	Diagnostic and Statistical Manual of Mental Disorders
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
LRA	Lord's Resistance Army
MHPSS	Mental Health and Psychosocial Support
NGO	Non-Governmental Organisation
OPM	Office of the Prime Minister
PTSD	Post-Traumatic Stress Disorder
RWC	Refugee Welfare Committee
SAF	Sudanese Armed Forces
SDG	Sustainable Development Goal
SPLA	Sudan People's Liberation Army
SPLA-IO	Sudan People's Liberation Army – In Opposition
SPLM	Sudan People's Liberation Movement
SRS	Self-Reliance Strategy
STA	Settlement Transformative Agenda
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UPDF	Uganda Peoples' Defence Forces
WFP	World Food Programme
WHO	World Health Organization

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Chapter 1. Introduction

1. Aims and purpose of research

This thesis examines the social, moral, and political lives of humanitarian mental health interventions in the refugee settlement of Palabek, northern Uganda. It is written at the junction of two significant trends: the search for durable solutions for mass displacement, and the establishment of the field of global mental health as a key actor in the management of psychological suffering in the Global South. It interrogates the entanglements of psychological programmes with socio-economic conditions of chronic poverty and food insecurity, from policy discourses to refugees' phenomenological experiences of suffering. In so doing, it critically examines the political significance, as well as the therapeutic potential and limitations of mental health interventions in extremely resource-poor contexts.

While mental health interventions have been a feature of emergency assistance for decades, recent policy developments have introduced changes in the conceptualisation and delivery of psychological programmes. These developments are situated both at the global level – for example, in the increasing influence of the field of global mental health on both development and humanitarian policy and in the growing circulation of psychopharmaceuticals in the Global South – and at the local level, in the entanglement of current mental health approaches with Ugandan refugee management approaches, and with the country's reputation as a progressive and development-oriented 'refugee haven' on the African continent. By employing ethnographic methods, the thesis aims at contributing to knowledge around two key issues in the existing literature around refugee and global mental health.

The first issue concerns the nature and role of mental health interventions in the context of refugee responses, which needs to be recognised as intrinsically political. As pointed out by anthropologist Sharon Abramowitz, "[i]n Africa […] the interactions between international peacekeeping and psychiatry, mental health, and the psychosocial are not, and have never been, neutral, benign, therapeutic, or apolitical" (2014:5); rather, "[t]he history of large-scale mental health interventions is, at best, morally ambiguous" (Abramowitz and Kleinman 2008:219). Recent years have witnessed the establishment of the field of global mental health as a recognised actor in the humanitarian field has been acknowledged (Bemme and

Kirmayer 2020; Bäärnhielm et al. 2017; Patel et al. 2018). However, this shift seems to have largely been accepted without much questioning about its implications on the ground, within the specific contexts of complex socio-political scenarios such as humanitarian emergencies. This thesis critically examines the implications of psychological interventions in Palabek settlement, investigating their interrelations with the wider humanitarian and political context of Uganda, as well as with the global political economy shaping current therapeutic landscapes in displacement settings.

In this sense, this thesis contributes to the growing critical literature which has analysed the frequent unintended consequences of mental health interventions in the Global South, such as depoliticization and medicalisation. By medicalisation I mean a series of processes by which human experiences come to be framed, categorised, and treated as medical problems (Clark 2014; Schram 2000), and which are often accompanied by and enacted through "a series of other 'izations': individualization, biologization, and pathologisation" (Mills 2015:217). Humanitarian mental health programmes have often been argued to medicalise forms of distress which are considered normal, and even adaptive, in circumstances of structural adversity (e.g., Summerfield 1999; Kirmayer and Pedersen 2014; Fernando 2014). In recent years, the rise of mental health on the international policy agenda has arguably magnified this tendency (Mills 2018). Increasingly, social afflictions related to socio-economic, political, and structural challenges have been constructed and explained in psychological and psychiatric terms. Howell (2011) and Mills (2015) have described this process as one of 'psychologisation' or 'psychiatrisation' of international development, respectively.

Furthermore, mental health programmes, particularly when implemented in the Global South, have often been noted to perpetrate forms of 'epistemic violence' or 'injustice' (Watters 2017; Cox and Webb 2015; Burgess 2022), instances in which one system of knowledge is validated over another, thus replicating colonial dynamics of knowledge production and imposition, frequently resulting in real needs being obscured. These notions are embedded in frameworks of decoloniality in global mental health (see e.g., Kumar 2023; Burgess 2020). I should note that this research did not explicitly investigate (post)colonial ideologies and practice in global psychiatry; nevertheless, the findings put forward by this thesis have implications for a wider project of decolonisation of global (mental) health (Chapter 10).

However, despite the large body of critical literature raising issues embedded in emergency mental health programmes, little is known about how these interventions are understood, experienced, and engaged by people at the receiving end of them in the Global South, or about the social ramifications of these interventions in circumstances of extreme structural adversity. The second main issue that this thesis speaks to is thus the lack of literature in refugee and global mental health which investigates first-hand experiences of mental disorder and treatment among people living with various forms of psychological affliction (Jenkins 2015; Meyers and Yarris 2019). First-hand perspectives on suffering and psychological interventions are vital to complement existing theoretical critiques of humanitarian and development therapeutic programmes, which have often traced their epistemological, historical, and often colonial roots in great detail.

Kohrt and Jallah (2016) have noted that the field of global mental health suffers particularly from a lack of research centring people's lived experiences of mental illness, pointing out that this "experience gap" (ibid:264) may often result in theoretical critiques dominating the debate, to the detriment of arguments which more closely relate to people's everyday realities. As Jain and Orr (2016) point out calling for ethnographic and studies in global mental health research, global mental health studies are mostly based on statistical and indirect evidence. With experience-near evidence generally missing from current debates, arguments for 'what works' in refugee and global mental health can often be considered largely speculative.

There is, therefore, a dire need for research focusing on experience-near perspectives of those who are at the receiving end of psychosocial interventions. This is particularly true in the case of populations such as refugees and forced migrants; at the time of writing, a jarring and unprecedented 108 million people are forcibly displaced worldwide (UNHCR 2022b), and the figure is anticipated to rise to over 117 million by the end of 2023 (UNHCR 2023). Often considered to experience higher rates of social suffering and mental disorders, refugees and crisis-affected populations embody a frequent paradox of current global (mental) health approaches; while hyper-targeted by humanitarian interventions, their voices, knowledge, and experiences remain under-researched and absent from the literature – particularly in the case of populations located in the Global South.

However, studies centring the voices and experiences of displaced individuals and communities are particularly critical at the current time, as emerging evidence suggests that, in many ways, current (global) mental health approaches and interventions in refugee settings can be described as failing. Assumptions that community psychosocial interventions lead to long-term mental health benefits are increasingly being challenged (e.g., Bryant et al. 2022); at the same time, despite the continuous expansion of mental health and psychiatric resources and facilities in displacement settings, extremely low rates of engagement with these services are recorded among refugee populations (e.g., Fine et al. 2022). Manifestations of low engagement vary, ranging from lack of visits to mental health services, to withdrawal from care after initial clinical encounters.

Understanding refugees' engagement (or lack thereof) with mental health interventions seems to me to require an exploration of the complex realities of the ways in which psychological suffering is understood and experienced. In the production of 'engaged anthropology' (Ortner 2015), foregrounding refugees' phenomenological experiences of affliction emerges thus as crucial to understand suffering and mental disorder within the local moral and socio-cultural worlds in which people's lives are embedded, as well as to the construction of modes of care for refugees' mental health grounded in epistemic and social justice. This, in turn, highlights the need for in-depth investigations of the ways in which displacement itself is experienced, embodied, and navigated by refugee individuals and communities, in line with what the anthropological literature has increasingly suggested (e.g., Ramsay 2020; Schiltz et al. 2019; Haas 2017; El-Shaarawi 2019).

Based on long-term ethnographic fieldwork, this thesis sheds light on South Sudanese refugees' phenomenological experiences of displacement and mental health in Uganda, and the interrelation of socio-economic and structural constraints with relational, moral, and gendered dimensions of personhood. In so doing, it highlights the existential and psychological impact of food insecurity, chronic poverty, and temporal dispossession experienced by refugees in Palabek settlement, showing the fundamental disconnect between psychological interventions and refugees' everyday realities. Finally, the thesis proposes ways to reimagine refugee mental health as departing from refugees self-identified priorities, firmly grounded in the complexity of people's lived experiences, and driven by explicit epistemic and social justice concerns.

2. An overview of the theoretical fields

2.1 Refugee mental health: a brief history

The ethnographic analysis of mental health programmes in Uganda put forward by this thesis requires a brief historical contextualisation of the evolution of the fields of refugee mental and humanitarian psychiatry. Recent research has shown that the emergence of the field of 'refugee mental health' far precedes that of 'humanitarian psychiatry', usually traced to the end of the Cold War, when humanitarian aid evolved from the provision of palliative support to active involvement in peacekeeping activities in war-affected areas (Kienzler and Pedersen 2012). Ibrahim (2021) shows that interest in the psychological consequences of conflict and violence began in the aftermath of the Second World War (WWII), when a large amount of research by psychiatrists and psychoanalysts investigated states of affliction in European refugees who were resettled in new countries.[1]

Over time, the hardship related to displacement has been pathologized through a multitude of different paradigms. During the 1940s and 1950s, for example, research on refugee mental health was dominated by assumptions that refugees' suffering was mainly caused by the condition of 'uprootedness', that is in the loss of a home and of cultural ties (Ibrahim 2021). Malkki (1992) has noted that implicit in this understanding of refugees' suffering is a spatial and sedentarist assumption which identifies someone's homeland as the best possible (even 'natural') environment where to reside, at the same time constructing individuals' identities as inherently problematic in a foreign land. This territorial assumption provided a framework under which refugees' suffering emerged from difficulties in adapting to a new country.

Mental health was mostly absent from humanitarian intervention in the 1960s and 1970s, when the problem of European refugees had largely faded, and the African continent emerged instead as the main recipient of UNHCR aid due to the widespread violence and political upheaval that characterised the recently independent former colonies. Knowledge acquired about European refugees was not transferred to African ones, reflecting a fundamentally

[1] This does not imply that forced migration and related conditions of suffering are new phenomena, as forced mobility related to conflict and persecution is a feature present in any time of recorded human history. As historian Peter Gatrell (2015) has noted, however, it was only with the collapse of European empires brought about by the First World War (1914-1918), and with the drawing of nation-state borders in its aftermath, that the legal category of 'refugee' came into being.

different approach of humanitarian policy and practice to these populations. Largely, this stemmed from an institutionally widespread understanding of African refugees as a political and economic problem, to be tackled entirely through development assistance (which had long been intimately tied to humanitarian aid in the African continent). With the solution to the African ‘refugee problem’ identified in measures aimed at refugees’ self-sufficiency, approaches centring experiences of ‘uprooting’ developed in Europe found little resonance (Ibrahim 2021). As anthropologist Barbara Harrell-Bond (1986) noted decades later, this approach was underpinned by racist and colonial stereotypes widespread among relief workers, such as the assumption that African forced migrants did not have the capacity to feel suffering in the ways in which those in the Global North would.

While African refugees’ psychological state was not understood through ‘uprooting’ frameworks, psychiatric language continued to be utilised to describe refugees’ predicaments and attitudes – particularly with regard to encampment. Refugee camps have long been a central feature of ‘humanitarian governance’ (Barnett 2013), often described as spaces of ‘care and control’ (Malkki 1997). The pathologisation of encampment had begun in Displacement Camps in Europe, both during and in the aftermath of WWII, which were identified by psychoanalysts as sites which led to refugees’ otherwise repressed, ‘primitive’ behaviours to prevail. Attitudes of idleness and dependency were widely medicalised, as indicated by the emergence of the diagnosis of ‘Displaced Person Apathy’ in the 1940s (Ibrahim 2021). In Africa, on the other hand, the pathologisation of encampment became evident with the notion of ‘dependency syndrome’, clearly evocative of psychiatric language, which was widely applied to refugees in camps across the Global South in the 1980s.

Several authors have challenged the notion of ‘dependency syndrome’ (e.g., Allen and Turton 1996; Easton-Calabria and Omata 2020). In particular, Harrell-Bond’s work (1986) showed that the concept was not only far from representative of refugees’ lives and agentic survival strategies, but that any attitude of dependency stemmed from the ways in which aid was managed and distributed. However, the notion of ‘dependency syndrome’ became widely used, allowing for the stigmatisation of refugees’ attitudes considered idle or problematic; the tendency towards the individualisation of signs of distress, and the lack of consideration for socio-political and environmental factors, with which this thesis is concerned, emerge here as longstanding features of refugee governance.

Interest in the psychological condition of refugees and forced migrants skyrocketed in the late 1980s and 1990s, with the establishment of the 'trauma' paradigm which has since largely dominated understandings of the 'refugee condition' (Summerfield 2000; Watters 2001). The notion of 'trauma' had long been popular in psychoanalytic practice (Fassin and Rechtman 2009), but prominently emerged in psychiatric and popular imaginaries in the aftermath of the Vietnam War in the United States. The precarious political equilibria created the need for a framework able to contain widespread social outrage about the atrocities committed by American troops during the conflict, while at the same time legitimising the acute forms of suffering and poor social adjustment displayed by returning soldiers (Young 1995; Summerfield 2001; Kienzler 2008). The diagnosis of post-traumatic stress disorder (PTSD) which emerged in 1980 has been argued to have been 'invented', rather than 'discovered' (Young 1995), to soothe social discontent in this historical context, and it quickly established itself a "prominent cultural model for understanding the suffering that can be caused by a wide variety of traumatic experiences" (Breslau 2004:113).

The diagnosis had an almost immediate, and exceptional, success; in an often-quoted statement, Nancy Andreasen, editor of the American Journal of Psychiatry between 1993 and 2006, described how "The concept of PTSD took off like a rocket, and in ways that had not initially been anticipated" (2004:1322). From veterans, the diagnosis began to be widely applied to Indochinese refugees resettled in the United States upon fleeing Vietnam, as well as the Khmer Rouge regime in Cambodia. With the establishment of the notion of 'trauma' and the emergence of the diagnosis of PTSD, the cause of refugees' suffering came to be constructed as located not in the 'uprootedness' of displacement, nor in experiences of encampment, but rather in the violence to which war-affected individuals and communities had been exposed. Thus, PTSD entered the 'global arena' through humanitarian psychiatry – first in US-led relief efforts in Cambodian refugee camps (Ibrahim 2021), then in assistance to northern Armenians affected by a devastating earthquake in 1988 (Breslau 2004; Fassin and Rechtman 2009).

It was in the context of the humanitarian response to the genocides in Bosnia and Rwanda in the early 1990s that the 'trauma paradigm' in refugee mental health really boomed, leading to the implementation of countless – and often ill-defined and epistemologically dubious – 'trauma interventions' (e.g., Bracken et al. 1995; Summerfield 1997, 1999; Pupavac 2001). PTSD was often noted to have become a form of political currency (James 2010), attributing

legitimacy to suffering by virtue of the symbolic power of scientific knowledge on which the diagnosis is predicated (Breslau 2004). Crucially, this fostered a vast industry in which legal and clinical practitioners, policymakers, researchers, and 'victims' themselves all participated in the reproduction of scientific legitimacy of suffering provided by the 'trauma' and PTSD model (James 2011; Fassin and Rechtman 2009).

With the expansion of humanitarian mental health programmes, notions of trauma and PTSD have become part of the flow of knowledge from Euro-American settings to war-torn societies worldwide (Breslau 2004), coming to constitute what Pillen (2000) has called 'trauma discourses'. The pervasive way in which 'trauma discourses' have increasingly populated popular, emotional, and crisis imageries in the Global North has been mirrored by the variety of actors that use the notion of 'trauma' in humanitarian settings – researchers, donor agencies, the United Nations, psychiatrists, NGOs, and local professionals trained by Western staff. While the use that each of these actors makes of this word often differs according to context and purpose, they all can be said to draw their practice from Western 'trauma discourses' (Pupavac 2001; Abramowitz 2014).

2.2 The 'psychologisation' of humanitarian assistance [2]

The increased relevance of mental health in the relief industry and the wide implementation of humanitarian interventions aimed at reducing psychological suffering have been referred to as a process of 'psychologization of humanitarian aid' (Torre 2019; De Vos 2011). This is reflected in a profound change of what Craig Calhoun (2010) has called the 'emergency imaginary'. Meanwhile, widespread narratives of 'trauma' and 'invisible wounds' have led to the conceptualisation of humanitarian emergencies as 'mental health epidemics' (Summerfield 1999; Epping-Jordan et al. 2015). Consequently, the understanding of crises has been increasingly channelled through the language of emotional dysfunction, with humanitarian policy taking a progressively more therapeutic and curative stance towards conflict-affected and displaced populations, which the 'trauma' paradigm constructs as traumatised en masse.

[2] This section builds on an in-depth literature review on the history of humanitarian psychiatry which I have published during my PhD, see: Torre, C. (2019). *Psychosocial Support (PSS) in War-affected Countries.* Working Paper No. 3, Politics of Return. London School of Economics and Political Science. https://eprints.lse.ac.uk/100199/1/Torre_PSSin_War_affectedCountries.pdf

The rise of PTSD and the 'trauma' paradigm in humanitarian psychiatry and refugee mental health have not gone unchallenged; rather, the 1990s and early 200s can be said to have been dominated by a lively – and at times ferocious – intellectual debate on the clinical utility and wider political implications of this model. Critical scholars showed that the pervasiveness of psychosocial approaches to emergencies often constitutes a form of governmentality. Vanessa Pupavac's work (2001, 2005), for example, identified the growth of humanitarian psychiatric programmes as the rise of a 'global therapeutic governance' paradigm in international development policy and humanitarian practice. Pupavac argued that psychosocial interventions, as they have often been framed by the World Bank and other development organizations, are underpinned by a 'social risk management' approach – a way of understanding the management of disaster-stricken populations as contingent on the governance of their psychology. In humanitarian emergencies, this approach translates in the wide implementation of psychosocial interventions as a form of 'therapeutic governance' to manage and minimise social risk, thus establishing a link between therapeutic well-being of individuals and communities, and notions of 'human security' (ibid. 2005).

Furthermore, significant concerns have been raised about the cross-cultural relevance of notions of 'trauma' and PTSD, which have been noted to be rooted in Western, Judeo-Christian models of personhood, memory, suffering, and healing which may not be applicable in non-Western settings (Bracken et al. 2002; Young 1995; Summerfield 1999). Such aspects of PTSD have raised questions about its applicability in non-Western contexts. Authors such as Summerfield (2004), Pupavac (2001), Eisenbruch (1991), Kienzler (2008) and many others have argued that the cross-cultural application of PTSD diagnosis constitutes what Kleinman (1977) has referred to as 'category fallacy' – the application of a Western category in settings where it is irrelevant. Arguments leveraged by anthropologists and transcultural psychiatrists have also emphasised that the diagnosis leads to the medicalization of human reactions to experiences of suffering, political insecurity, chronic poverty, and marginalisation commonly found in ongoing and post-conflict situations (Miller and Rasmussen 2010; Pedersen et al. 2015; Savic et al. 2016; Behrouzan 2015), based on Western psychiatric views of what is considered 'normal' or 'pathological' (Kienzler 2008; Summerfield 2004; Bracken et al. 1995.

Despite being widely contested, there was no doubt that 'trauma paradigm' was there to stay. Its discursive and policy influence constituted a significant shift in the global humanitarian landscape; by the end of the 1990s mental health of war-affected and displaced populations had become a central preoccupation of emergency assistance, leading to the emergence of the field today known as Mental Health and Psychosocial Support (MHPSS), which became systematised in 2007 with the IASC guidelines on mental health and psychosocial support in emergencies (IASC 2007). The need for guidelines stemmed from a recognition of the MHPSS arena of interventions as a "historically divided, polarised, and badly coordinated field" (Tol et al. 2015:485), which was in need of standardised definitions, shared ethical standards, and practical guidance on minimum requirements for programme implementation. Crucially, longstanding divisions within the field revolve around understandings of states of affliction as caused mainly by trauma-related symptoms (which are mostly tackled through a biomedical approach), as opposed to frameworks which instead centre social, political, and economic determinants in the conceptualisation of refugees' causes of distress (Wessels and Ommeren 2008)

While well-intentioned, the IASC guidelines have been described as largely unsuccessful in uniting or clarifying the scope and nature of the MHPSS field (Marshall 2022). The issues begin with the guidelines' definition of 'mental health and psychosocial support', intended to be general, ostensibly in order to encompass the variety of existing MHPSS programmes, which define these interventions as "any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder" (IASC 2007). This description, however, has been pointed out to be so broad as to be essentially meaningless (Haroz et al. 2020; Kohrt and Sang 2018); in the IASC definition of psychosocial support, "the meanings of mental health, trauma healing, and psychosocial disorders, as well as the scope of their interventions, are obscure" (Abramowitz 2014:13). Meanwhile, divisions within the field (which largely replicate the 'psychocentric' vs. 'social determinants' discussions around PTSD) are far from being fully resolved; rather, scholars have pointed out that biomedical approaches rooted in Western psychopathological models of distress remain the most widely implemented, to the detriment of interventions focused on social determinants of suffering in circumstances of structural adversity (Marshall 2022; Hillel 2023).

Crucially, furthermore, there is a growing acknowledgement of the lack of an evidence base for the vast majority of commonly implemented MHPSS programmes, such as short-term psychological interventions (IASC 2014; Haroz et al. 2020; Chiumento et al. 2017; Summerfield 2008; Bangpan 2019). Even when benefits on participants' mental health can be demonstrated in the short-term, these results disappear when measured one year after the delivery of the interventions (see e.g., Bryant et al. 2022), indicating the inadequacy of these programmes to provide locally meaningful and sustainable support to displaced and crisis-affected populations.

The MHPSS field remains widely contested; however, neither the dearth of evidence-base for most psychosocial interventions, nor internal divisions and disagreements on fundamental understandings of suffering and healing have deterred mental health from occupying an increasingly prominent place in humanitarian policy. Over the past fifteen years mental health interventions in humanitarian settings have continued expanding, increasingly intersecting with international development agendas. The emergence and expansion of the field of global mental health significantly contributed to this process (Mills 2018).

2.3 The rise of global mental health in the humanitarian field

Over the past fifteen years, global mental health has strived to establish itself as an influential actor in mental health policy and practice worldwide (Jain and Orr 2016). Its emergence is often pinpointed to two Lancet Series, published in 2007 and 2011 respectively, which articulated the field's agenda and epistemological approach (Lancet Global Mental Health Group 2007; Patel et al. 2011). However, Lovell and colleagues (2019) have traced its ideological roots to the 1978 Alma Ata Declaration, a seminal moment in the recent history of public health, which identified primary health care approaches as key to universal access to healthcare (Rifkin 2018). A second, fundamental moment for the history of global mental health was the publication of the World Health Organization (WHO) 1996 Global Burden of Disease (GBD) study (Murray et al. 1996), which for the first time brought the idea of the 'burden' of mental disorders to a wide audience, introducing the DALY (Disability Adjusted Life Years) indicator to measure the impact of psychiatric illness and mapping the latter's distribution worldwide (Lovell et al. 2019). The GBD and the DALY indicator played an essential role in global mental health's discursive strategy, contributing to crafting a moral narrative around access to mental health care in resource-poor contexts. Both measures,

furthermore, formed the basis for the widely influential WHO 2001 World Health Report (WHO 2001), entirely dedicated to mental health, which put forward many of the principles at the core of global mental health's goals today.

Lovell and colleagues' (2019) are careful to note that global mental health should be understood "not as a hegemonic given, but as an unstable, dynamic and provisory assemblage of, among others, international agencies such as the WHO and the World Bank, academic institutions, research funding bodies, philanthropists, non-governmental organizations (NGOs), advocacy groups, metrics and their architects, professional bodies and those identified as service users, engaged in the production and circulation of technologies, principles and practices" (ibid:520). Despite this internal diversity, global mental health advocates have been able to create an easily identifiable (and arguably very catchy) "umbrella language" (Bemme and Kirmayer 2020:5) through which, as Cooper (2016b) notes, the field quickly gained the attention of global development agencies and international donors.

Ever since its early days, the field of global mental health has had one relatively straightforward goal: to close the 'treatment gap' – that is, the difference between the number of people estimated to be in need of mental health treatment, and those actually receiving treatment – worldwide, but especially across low- and middle-income countries across the Global South in which trained psychological and psychiatric professionals are few (Saxena et al. 2007). Essential to this goal is the idea of 'scaling-up' evidence-based interventions, and the project of integrating mental health care into primary health care in a cost-effective way through 'task shifting' – essentially, the principle that psychiatric and psychological interventions can be implemented in a simplified version by lower-level health workers (Bemme and D'Souza 2014; Ventevogel 2014; Barbui 2022). Global mental health's discursive strategy makes a strong moral case for improving access to mental health care (Patel and Saxena 2019), often evoking notions of a 'shared humanity' (Bemme and D'Souza 2014) and heavily relying on GBD and the DALY indicators when stating the significance of closing the 'treatment gap'.

In many ways, global mental health advocates have been extraordinarily successful in making the mental health of individuals and communities living in resource-poor contexts a priority for international development and global health institutions – recently manifested in the 2015 inclusion of mental health and well-being as a global priority in the Sustainable Development

Goals (SDGs) (Mills 2016; UN General Assembly 2015). However, a large and growing critical scholarship has looked with suspicion at the growing influence of global mental health on international public health policies, as well as at the myriad of interventions spurred by the growth of the field, identifying global mental health as one of the main drivers of the global expansion of psychiatry (Fernando 2017; Kirmayer and Pedersen 2014). Critics have pointed out that global mental health interventions tend to export Western biomedical frameworks which overlook the role of culture, context, values, and relationships in shaping manifestations and meanings of distress, as well as people's experiences of the latter (Angell 2011; Summerfield 2008; Beeker et al. 2021), arguing that in its disregard for locally relevant expressions of distress (and strategies to alleviate it) global mental health perpetuates a form of psychiatric neo-imperialism (Summerfield 2013).

Unlike trauma-focused interventions, which historically have rarely acknowledged the role of environmental, socio-economic, or political factors in contributing to individuals' distress, global mental health is characterised by a strong discursive focus on multi-layered inequalities, ostensibly integral to the field's practical approach (Bemme and Kirmayer 2020; Patel et al. 2018). In reality, however, global mental health practice tends to be rooted in biomedical psychiatric frameworks and in psychopathological models, which construct mental distress as 'an illness like any other' for which a 'technical' solution is best suited (Bracken et al. 2012). Global mental health advocates for the employment of a 'standard approach' to mental distress (Mills 2016); often, within such biomedical frameworks, pharmacological treatment is identified as the main solution to psychological suffering (Vorhölter 2021). Despite attempts on the part of both the global mental health and the WHO to distance themselves from over-reliance on psychotropic medications (Ecks 2017), pharmacological treatment remains a frequently employed therapeutic pathway in global mental health interventions. While, as pointed out by Bemme and D'Souza (2014), global mental health's universalism should at least partly be understood as an advocacy and fundraising strategy, rather than an ideological stance, the result is often that the role of social and structural determinants of mental health – such as the role of poverty, inequality, insecurity, and marginalisation – remains ignored.

In recent years, global mental health frameworks, knowledge, and interventions have been increasingly channelled in refugee contexts across the Global South (see e.g., Tol et al. 2020; Acarturk et al. 2022; Kronick et al. 2021). The designation of refugee settings as the new

frontier of global mental health is far from coincidental and rather needs to be understood as related to attempts of global mental health to assert its legitimacy as a field of research and practice. Global mental health experts and practitioners entertain a close relationship with the WHO (Lovell et al. 2019; Littoz-Monnet 2022), which has largely incorporated global mental health's ideological, epistemological, and practical approach to psychological suffering, in turn informing the approach of other UN agencies, including the United Nations High Commissioner for Refugees (hereafter UNHCR). Furthermore, within the renewed attention that the humanitarian-development nexus has received since 2016 (Lie 2020), particularly manifested by the 2018 Global Compact on Refugees (Zetter 2018; see Chapter 2), humanitarian and development priorities are increasingly conflated, particularly in the context of refugee responses in the Global South. Meanwhile, mental health had risen among development priorities (UN General Assembly 2015). Under a more development-oriented framework, humanitarian mental health was largely incorporated by global mental health policy; in this context, emergencies were identified as opportunities to further health system development and reform.

This is not an entirely new phenomenon; humanitarian emergencies have often represented opportunities for international actors to channel public health reforms, who frequently assume these spaces to constitute apolitical bubbles in which innovative interventions can be piloted and scaled-up (Kienzler 2019; Abramowitz and Panter-Brick 2015). This, it is crucial to note, constitutes a largely inaccurate assumption. As Allen points out, humanitarian intervention seems to frequently rely on a form of 'cognitive dissonance' in which "emphasis is placed on the intention to assist […] at the expense of engagement in local complexities or assessment of what exactly is being achieved" (2015:97). Often, this has detrimental consequences for the population which the humanitarian apparatus set out to assist. As several scholars have noted, humanitarian intervention can often be complicit in, and indeed exacerbate, large-scale forms of persecution, systematic abuse, and human rights violations (see e.g., Dolan 2009; Finnström 2008). Nevertheless, such is the prevailing rationale in humanitarian operations; that the spaces where aid is channelled do not constitute complex and intricate arenas fraught with conflictual actors and inequal power dynamics (see e.g., Hilhorst and Jansen 2010), but rather blank canvasses onto which new policies can be shaped.

From an institutional perspective, the influx of resources that often characterises humanitarian crises also constructs emergencies as significant development opportunities for

the affected regions. This is true for mental health systems, too; as detailed in the 2013 ‘Building Back Better’ report, the WHO explicitly identifies humanitarian emergencies as a chance to rethink and improve existing mental health systems in affected countries (WHO 2013). With mental health increasingly dominating popular and institutional ‘emergency imaginaries’ (Calhoun 2010), psychological interventions often become a priority in emergency settings (Kienzler 2019). This has important implications for the ways in which funding is channelled into humanitarian contexts and operations, allowing resources to be allocated to mental health in ways shaped by prevailing actors and discourses. Humanitarian emergencies’ ability to catalyse mediatic attention and elicit public sympathy, therefore, makes the depictions of crises as ‘mental health epidemics’ instrumental to the introduction of global mental health interventions and policy (Epping-Jordan et al. 2015).

It is worth pointing out here that the psychologization of humanitarian aid also highlights the circular and interdependent nature of the relationship entertained by the fields of global mental health and humanitarian policy. As thoroughly described by Littoz-Monnet (2022), ever since its early days the global mental health assemblage has relied on forms of circularity of knowledge production construct and solidify its expertise. Global mental health’s increasing presence in emergency situations can be understood as an additional manifestation of the same phenomenon. Over the past two decades, global mental health interventions have been increasingly targeting the psychological wellbeing of conflict and disaster-affected populations (e.g., Tol et al. 2020; Jones and Ventevogel 2021), thereby generating a significant overlap between the MHPSS field and that of global mental health (Silove et al. 2017). On the one hand, this can be read as a rise in influence of global mental health policy in humanitarian emergencies. On the other, studies carried out in emergency settings have significantly contributed to legitimising global mental health action, by generating some of WHO’s most impactful figures on the rate of mental disorders in low-resource settings. Some of these statistics, for example, estimate the prevalence of mental disorders (i.e., depression, anxiety, post-traumatic stress disorder) among displaced populations at a jarring 22%, and that of severe mental disorders (i.e., schizophrenia, bipolar disorder, severe depression, severe anxiety, and severe post-traumatic stress disorder) at over 5%, at any given point in time (Charlson et al. 2019).

While these and other statistics, such as the GBD and DALY figures often cited in relation to the ‘treatment gap’, have been criticised for being excessively alarming (e.g., UN Human Rights Council 2017), they have laid the foundation for the implementation of countless

interventions, constituted the rationale for conferences, training programs and university courses, and contributed to shaping the trajectory of funding streams. Summerfield (2008) notes that psychiatry lacks solutions (and evidence) for the 'ontological problem' of what constitutes a mental disorder; more recently, Jenkins (2015) has questioned the existence of clear boundaries between pathological and non-pathological conditions. As there is no firm agreement on what concepts like mental health and mental disorder may mean within Euro-American contexts, the epidemiological figures on which global mental health relies can hardly be said to communicate anything about the scale of mental illness worldwide; rather, the utility of these studies resides largely in raising the profile of global mental health (Mylan et al. 2019; Torre et al. 2019). Yet, the role of these figures in establishing global mental health actors as key decision-makers in international policy hubs cannot be underestimated. As several authors have emphasised, the field of global mental health has relied on a strategic and convincing public discourse to legitimise its existence, operations, and funding pledges (Campbell and Burgess 2012; Iemmi 2022; Mills and Hilberg 2019). By establishing a circular and mutual relationship with humanitarianism, therefore, global mental health has found in emergencies an essential channel through which to assert its own relevance.

To be clear, here I do not wish to suggest that refugee mental health and global mental health are two separate fields of research and practice, nor that global mental health is simply the 'new face' of MHPSS. Rather, I follow Lovell and colleagues' (2019) suggestion to avoid thinking of the development of fields of research and practice in terms of absolute ruptures. Just as 'humanitarian psychiatry' and 'refugee mental health' only partially overlap, so do global mental health and MHPSS. This thesis does not simply aim at replicating the important considerations that have been put forward in debates around trauma and PTSD, but rather is interested in analysing how the rise of global mental health shapes, and is shaped by, the landscape of humanitarian responses to refugees' affliction in Uganda.

2.4 Uganda's historical entanglements with mental health interventions

The current psychosocial humanitarian arena of Palabek, which the empirical chapters of this thesis explore, needs to be understood as in continuity with northern Uganda's long history of implementing mental health interventions and fostering research on the subject. Mental health interventions were first introduced in the country in the early 1990s as part of the World Bank's 'social protection' packages, and were funded and implemented in the context of

widespread poverty reduction efforts which the country had been undergoing since the current president, Yoweri Museveni, rose to power in 1986 (Yen 2018). The first forms of psychological counselling and talk therapies that were introduced under these measures sought to foster 'coping mechanisms' to face the so-called 'social costs of adjustment' that were understood as a necessary evil, and to which the government's defunding of health infrastructure inevitably contributed (Branch and Yen 2018).

Vaughan (2016) identifies several genealogies of psychological interventions in East Africa. Among these, two have been particularly relevant in Uganda. On the one hand, the history of forms of counselling and psychological programmes in the country is inextricably linked to the history of public health responses to HIV/AIDS, which have been particularly intense in the country since the 1990s (Whyte et al. 2004). The HIV/AIDS pandemic provided the rationale for a first introduction of self-help and other kinds of psychological therapies, which became particularly associated with medical advice when antiretroviral therapy became widely available in Uganda in the mid-2000s (Wilhelm-Solomon 2016). The infrastructure of AIDS counselling, as noted by Meinert and Whyte (2020), laid the grounds for the mainstreaming of trauma-focused psychosocial interventions both during and in the aftermath of the bloody 'Bush War' that ravaged the north of the country between 1986 and 2006 (Torre et al. 2019). The horrific accounts of widespread abductions, mass killings, and physical and sexual violence, which characterised the civil war, made the notion of 'trauma' central to the narrative around the region, where the population was described as being traumatised en masse (see e.g., Pfeiffer and Elbert 2011; Nakimuli-Mpungu et al. 2013), and rates of PTSD were said to be among the highest ever recorded (see Roberts et al. 2008). Trauma fostered an enormous industry of both humanitarian work, and academic and clinical research in northern Uganda. Indeed, as Yolana Pringle has described in her insightful book on post-colonial psychiatry in the country, "at a time when research on trauma was still in its infancy internationally, Uganda and Ugandan refugees became the subject of some of the earliest research on the psychological effects of war and violence in Africa" (2019:179). The LRA war also facilitated the growth of psychiatric care in northern Uganda – for example, through the renovation, expansion, and construction of mental health wards in hospitals across the country.

From early on, and indeed at a time in which mental health was still far from becoming a development priority, psychological programmes in the country were deeply entangled with

international development efforts, and often largely facilitated by humanitarian operations. This is true for the introduction of psychiatric medications too; Branch and Yen (2018) have traced the introduction and quick spread of psychopharmaceuticals in northern Uganda to peacebuilding efforts unfolding in the region, following the end of hostilities. As this thesis show, furthermore, the current refugee emergency has allowed for the unfolding of the most recent developments in mental health interventions delivered to refugees, providing fertile ground for the expansion of global mental health thinking and practice. The ethnographic material presented in this thesis explore the manifestations and consequences of this shift, as it emerges from an analysis of both community psychosocial programmes (Chapter 5) and psychopharmacological interventions (Chapters 6 and 7).

3. Stating the argument

This thesis investigates mental health interventions in Palabek refugee settlement – a context where the life of most refugees is characterised by chronic poverty, food insecurity, and acute social suffering – and their entanglements with refugees' daily lives. It does so adopting a scalar structure, in which the main argument is developed through a macro to a micro perspective; from interrogating the role of mental health interventions within the broader policy landscape of the current Ugandan (and global) forced migration regime, to investigating the social implications of some of the most commonly implemented interventions, and finally to an analysis of mental health programmes in relation to refugees' phenomenological and embodied experiences of displacement in Palabek.

Mental health interventions aimed at refugee populations in the Global South are often discussed and problematised in terms of their adherence to socio-cultural understandings of mental health and illness. This thesis aims at complicating this argument, by showing that a narrow understanding of culture leads to the disregard of the role of socio-economic and structural characteristics that underpin the context in which displaced individuals and communities access mental health care. In so doing, this thesis challenges the concept of treatment gap on which the global mental health movement has long been based.
Reflecting my interdisciplinary background, situated across clinical psychology, development studies, and medical anthropology, this thesis aims to contribute to debates on refugee policy

and global mental health, as well as to growing medical and psychological anthropology scholarship exploring experiences of mental illness in circumstances of chronic adversity. The contributions of this thesis can be conceptualised as threefold.

Firstly, the thesis shows that forms of suffering experienced by refugees in Uganda are shaped by the structural constraints of life in displacement, where refugees' lived realities are far from the successful narrative often used to characterise the Ugandan approach to forced migration. In particular, this work investigates the existential and psychological consequences of chronic precariousness in Acholi men refugees, and explores phenomenological interrelations between Acholi relational experiences of temporality, moral personhood, and masculinity. I argue that Western psychopathological models of distress, with their narrow focus on symptomatic presentation, fundamentally disregard phenomenological, relational, and temporal dimensions of refugees' affliction, which, particularly in the case of men refugees, is intimately related to conditions of "temporal dispossession" (Ramsay 2020), and to a sense of moral and identity suspension which generates feelings of hopelessness. In so doing, I contribute to literature exploring the phenomenology of forms of 'social suffering' (Das 2007).

Secondly, this thesis seeks to emphasise the political role and connotation of therapeutic actors in the context of 'structural violence'. Structural violence is a complex notion which evades easy categorisation; foregrounding issues of poverty and deep social inequalities, it can be understood to result "from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems" (Kleinman et al. 1997:ix; Farmer 2004).[3] The thesis argues that, when divorced from direct engagement with forms of structural injustice, current global mental health approaches constitute forms of structural violence, and actively 'do harm' by contributing to refugees' psychological afflictions. This is the case of 'psychocentric' mental

[3] In using the notion of 'structural violence' in this thesis, I am aware of the critiques that the concept has received. In commentaries in response to Farmer's seminal article on structural violence, several anthropologists (including Nancy Scheper-Hughes, Didier Fassin, and Loic Wacquant) cautioned against the ill-defined nature of the concept, noting that its lack of nuance may obscure local and context-specific dynamics in which violence indeed arises (see Farmer 2004). More recently, Hirschfeld (2017) has noted that narratives of 'structural violence' risk being used as moral rhetorical tools, while empirical realities of social and health inequalities remain overlooked. These critiques are well-founded; in this thesis, I strive to avoid simplistic characterisations of structural violence, and instead continuously attempt to nuance, historicise, and empirically analyse dynamics through which it unfolds in the Ugandan refugee response.

health discourses and interventions in Palabek. Rimke defines ‘psychocentrism’ as “the view that human problems are due to a biologically-based flaw or deficit in the bodies and/or minds of individual subjects” (2016:5). For the purpose of this thesis, I propose to expand this definition to refer to the assumption that manifestations of psychological suffering must have their roots in psychological causes and require solutions which are primarily psychological. I argue that psychocentric interventions medicalise forms of affliction related to socio-economic, material, and political dimensions of experiences of displacement, at the same time pathologizing dependency on humanitarian aid. In so doing, these interventions are discursively used to justify withdrawal of aid, thus masking the failures and shortcomings of the Ugandan humanitarian response.

This thesis shows that interventions’ entanglements with social and structural characteristics of the context also extend beyond the level of policy discourse and become especially visible by way of their implementation. The introduction of psychocentric mental health interventions in Palabek clashes with the reality of extreme and chronic scarcity of material resources, and the lack of alignment with structural and political circumstances shaping people’s experiences of suffering makes programmes unable to significantly affect refugees’ mental health. Rather, by overlooking – and indeed intentionally disengaging from – socio-economic determinants of distress, interventions risk directly causing harm to refugee populations in Palabek settlement. While this occurs and could be discussed in a variety of ways, this thesis particularly explores the unintended and damaging consequences of the establishment of direct links between chronic poverty and mental disorder, which often shift the blame on individuals for being dependent on humanitarian aid where self-reliance cannot be achieved (Chapter 5) and, crucially, the creation of cycles of chronicity and worsening of mental disorders linked to the prescription of psychopharmaceutical treatment (Chapter 7). In both cases, the failure of mental health interventions can be identified in the disregard of priorities as identified by refugee themselves, which largely revolve around social, economic, and political conditions shaping their lives in displacement.

Thirdly, the thesis shows that the rise of global mental health in the humanitarian field has amplified tendencies already evident in the frameworks which have previously dominated refugee mental health, such as: the problematisation of refugees’ ‘culture’ of the ‘uprooting’ paradigm, characterised here as an obstacle to psychiatric help-seeking; the pathologisation of dependency on aid of the ‘encampment’ paradigm; and the medicalisation of socio-economic

distress of the ‘trauma’ paradigm. Moreover, I describe how global mental health’s influence on refugee mental health has furthered the psychiatrisation of refugees, by expanding biomedical psychiatric expertise in settlements, and by facilitating the widespread prescription of psychopharmaceuticals. To a large extent, the distribution of psychotropic medication has become an accepted and standardised practice in humanitarian emergencies; however, it remains a significantly under-researched area of humanitarian interventions. Furthermore, by becoming entrenched with national political and developmental agenda, mental health interventions come to reflect the political priorities shaping local humanitarian landscapes. In Ugandan refugee settlements mental health programmes enable the political abandonment of refugees; in so doing, these interventions reflect both the shortcomings of the relief apparatus, as well as the state’s lack of political will to engage with the long-term integration of refugees in the country. Finally, this thesis proposes new directions for refugee and global mental health. It argues for the need of a ‘temporal turn’ in refugee mental health which foregrounds refugees’ moral agency, and for the central role of livelihood interventions in allowing for the performance of ‘moral personhood’ (see below), generating therapeutic outcomes.

At its core, the main argument of this thesis is simple. What my ethnographic study of mental health interventions in Palabek settlement shows is that ‘context’, intended here as the aggregate of socio-economic, political, and structural characteristics of a setting, significantly shapes refugees’ experiences of mental health and illness, as well as attitudes towards humanitarian mental health interventions and – crucially – the perceived efficacy of the latter. Ideas of ‘culture’ and ‘context’ can only be artificially separated, as it would be an impossible (and perhaps pointless) task to try and pinpoint when the first former ends and the latter begins in human experience. In Jenkins’ words, “there is no such thing as an individual pathology”, as all forms of affliction “are invariably constituted by intersubjectivity, social and economic conditions of possibility and constraint, and the shaping of cultural expectations of persons in relation to gender, mental, and political status” (2015:3). However, the two concepts have often been treated as separate in refugee and global mental health, as well as in the transcultural psychiatry literature. Focusing on the idea of ‘context’ is helpful here to highlight how the notion of ‘culture’, as it is usually understood and approached in refugee and global mental health debates, tends to be simplified and reduced to a ‘thin’, static construct (Campbell and Burgess 2012; Kleinman and Benson 2006; Abramowitz 2010).

To be clear, in this study I do not suggest that structural and contextual factors such as food insecurity and chronic poverty constitute the only root of psychological affliction for refugees in Palabek. Nor do I seek to dismiss the role that culture plays in shaping expressions and experiences of suffering among Acholi (and East African) people, as pointed out by anthropological arguments about the cultural relevance (or more often lack thereof) of approaches to mental health designed in the Global North and subsequently 'exported' in the Global South (see e.g., Summerfield 1999). As Farmer has noted, despite himself highlighting the primacy of socio-economic dimensions and structural inequality, suffering is a complex, "textured" experience, hardly ascribable to one single causal factor (1997:262). As I describe throughout this thesis, Acholi refugees' experiences of affliction and mental disorder are characterised by the complex interrelation of several social, moral, economic, and phenomenological dimensions, and cosmological notions of 'good' and 'bad' significantly shape understandings of psychological suffering, as well as experiences of insecurity.

Rather, this thesis cautions against relying on simplistic understandings of 'culture' to frame issues related to help-seeking behaviours, efficacy, and experiences of mental health interventions in extremely resource-poor settings. Critical debates around mental health in the Global South (and particularly in Africa) have largely centred around ideas of 'cultural relevance' of interventions to explain engagement with the latter. Scholars have criticised this approach, arguing that culture-focused discussions in global mental health often revolve around reductive and technical understandings of culture, generally framed as merely a fixed set of beliefs to account for in intervention design and translation (Cooper 2016; Campbell and Burgess 2012; Jenkins and Kozelka 2017), rather than a complex process shaping the experience of 'being-in-the-world' (Das et al. 2014; Jackson 2005). This thesis aims to contribute to existing debates, arguing for the pivotal role of contextual factors and for the expansion of conceptualisations of 'culture' in refugee and global mental health, as "not a factor, but rather a pervasive process at work in nearly every aspect of mental health and illness" (Jenkins and Kozelka 2017:152).

My use of Acholi moral notions to understand and characterise refugees' affliction in Palabek finds its justification precisely in the attempt to include – and indeed centre – locally relevant notions of morality, personhood, and temporality in analyses of cultural dimensions of mental health and illness. These notions, I contend, highlight "fundamental human processes"

(Jenkins 2015) which allow for nuanced, agency-centred, and non-pathologising analyses of suffering in circumstances of adversity.

This thesis shows that humanitarian mental health interventions in Palabek settlement widely medicalise forms of affliction experienced by refugees, echoing decades of critical mental health and medical anthropology research studies have pointed out that psychological programmes in complex political settings lead to forms of medicalisation of suffering related to social, economic, and structural factors. The thesis therefore attempts to go beyond the reiteration of this argument, by now widely shared in critical social science. It does so by shedding light on an issue which has received limited attention – that is, the ways in which people exercise agency when confronted with interventions and institutions which overlook social and moral dimensions of their affliction. I show that, refugees in Palabek settlement are acutely aware that their suffering is being medicalised; [4] amid circumstances of chronic scarcity, insecurity, and 'temporal dispossession', such awareness leads psychocentric programmes to be perceived not simply as unhelpful, but as antagonistic and even hostile.

In so doing, this thesis demonstrates that in the face of interventions' disengagement from refugees' material circumstances, refugees enact a refusal to be 'managed', by withdrawing from mental health services. In this sense, this thesis contradicts arguments that see interventions' failures as attributable to notions of 'cultural models of distress', as well as understandings of non-compliance as arising from individual traits or lack of mental health literacy. Rather, I argue that disengagement from mental health services is itself a product of institutional disengagement from the socio-economic and structural circumstances shaping the "extraordinary conditions" (Jenkins 2015) of refugees' lives in displacement.

[4] While this is demonstrated through experiential narratives throughout this thesis, it is worth noting that this point emerges clearly from a statement reported on the website of the international NGO Kuja-Kuja (Swahili for the invitation 'Come-Come'). Kuja-Kuja, whose work focused on organisational accountability, interviewed refugees in Palabek about their experiences with the humanitarian apparatus, recording both their experiences of receiving assistance and their suggestions on how to improve it. Despite the challenges they faced within the "ecology of fear" (Das 2007; see Chapter 2) of Palabek settlement, where refugees at times struggled to trust them, and their interventions in meetings with representatives from institutions in charge of the emergency response consistently received lukewarm responses, Kuja-Kuja workers regularly uploaded refugees' perspectives on their publicly available website (see Kuja-Kuja n.d.). The statement of an anonymous refugee residing in Palabek settlement in October 2020 reads: "Mental health partners should advocate for us with livelihood partners to fight poverty because poverty is the cause of depression to us".

4. 'Culture' and 'context' in global mental health

As noted by Vorhölter (2021), anthropological discussions in the field of global mental health have tended to focus on culture, rather than socio-economic conditions. Indeed, the notion of 'culture' has been at the centre of a florid, and at times ferocious debate in global mental health over the past decade; such discussions have often been very productive, and it could be argued that the field has been enriched, improved, and diversified through them. Medical anthropologists have strongly advocated for the recognition, on the one hand, of global mental health's own cultural assumption and historical positioning (e.g., Summerfield 2008; Kirmayer and Pedersen 2014); and on the other, of the ways in which culture shapes understandings, idioms, and experiences of psychological distress. Mental suffering, they argue, like any human experience is embedded in systems of meaning specific to each sociocultural context, which in turn also provides the relevant tools to understand illness and deal with it (Mills and Fernando 2014; Pillen 2000). Critics have also warned against the erosion of local cultural notions of suffering and healing that the expansion of global mental health could cause (Kidron and Kirmayer 2019; Varma 2016). This led to a proliferation of discussions around ideas of cultural competence (e.g., Kirmayer 2012), cultural sensitivity (e.g., Anakwenze 2022), cultural adaptation (e.g., Heim and Kohrt 2019), and cultural humility (e.g., Ranjbar et al. 2020) aimed at making these programmes applicable and effective. The problem has often been framed as a 'lack of mental health literacy' (White and Sashidharan 2014; Watters 2017), and the solution identified in 'psychoeducation' interventions (e.g., Mills 2015), to raise mental health awareness among communities in the Global South.

Cultural considerations have been considered central in shaping all aspects of mental illness – from phenomenological experiences of affliction (e.g., Kaiser et al. 2015) to acceptability of interventions (e.g., Bolton 2019), and engagement with treatment (Patel et al. 2011). They have been particularly relevant in the study of help-seeking behaviours; both the limited evidence of the effectiveness of community interventions for common mental disorders (Bangpan et al. 2019) and longstanding low uptake in mental health services (Fine et al. 2022) have been explained with variations of the argument that the approaches proposed do not adhere with local cultural models of mental illness. However, Cooper (2016) has pointed out that both approaches focused on notions of 'cultural belief' (see e.g., Byrow et al. 2020; Baron 2002) and 'explanatory models of illness' (see e.g., Kleinman et al. 1978; Kirmayer and Bhugra 2009)

are based on Eurocentric assumptions and rigid polarisations between 'local' and 'Western' epistemologies, which are inadequate to explain the failures of mental health interventions and risk perpetuating forms of exoticisation of non-Western lifeworlds and understandings of mental disorders (see e.g., van der Geest 1984; Keys and Kaiser 2017).

Socio-economic, political, and structural dimensions of the local context have also been noted to contribute to the onset and course of mental disorders, and to significantly shape experiences of psychological suffering (e.g., Kirmayer and Pedersen 2014; Mills 2015). A solid body of literature has explored the role of the social determinants of mental health, demonstrating the profound impact of socio-economic conditions, such as poverty, unemployment, poor education, scarcity of basic resources, inequality, marginalization, political oppression, and multi-dimensional deprivation on the psychological wellbeing of individuals and communities (e.g., Patel and Kleinman 2003; Bracken et al. 2012; Kirmayer and Pedersen 2014). The association between poverty and mental disorder is "one of the most well established in all of psychiatric epidemiology" (Belle 1990:385; Mills 2015), particularly when major changes in life circumstances, such as displacement, are involved (Das et al. 2007). The 'social drift' argument, which suggests that circumstances of illness cause socio-economic hardship, has increasingly been side-lined (Bemme and Kirmayer 2020); the 'social causation' argument, which instead posits that people who live in poverty are more at risk of developing various forms of mental disorders, is generally accepted by global mental health scholars and advocates (Mills 2015), who are increasingly abandoning restrictive models of biomedical roots of mental disorders in favour of a recognition of the interrelation of structural, ecological, and sociocultural factors shaping psychological affliction (Lovell et al. 2019; Bemme and D'Souza 2014).

However, it is notable that, while a wide consensus exists that 'cultural' factors impact both the experience of mental disorder and help-seeking behaviour and engagement with treatment, the role of socio-economic and structural factors such as poverty, unemployment, and marginalization on the acceptability, efficacy, and symbolic meaning of psychosocial or psychopharmaceutical mental health interventions have received significantly less attention (Jenkins and Kozelka 2017; Biehl 2004). This thesis, therefore, seeks to move debates around mental health interventions beyond ideas of 'cultural sensitivity', instead emphasising the role of the socio-economic context and forms of social injustice as determinants of the relevance, efficacy, and outcomes of psychological programmes in resource-poor contexts.

These considerations are particularly relevant in the case of psychiatric medication. Anthropological scholarship has demonstrated the 'total' effect of medications is inevitably shaped by social and ecological factors (Hardon 2002; Etkin 1992; Kirmayer and Raikhel 2009), and that medications' effects are not relegated to their clinical and chemical impact on bodies, but rather that they inevitably affect social relations (Whyte et al. 2002; Jenkins and Kozelka 2017; Whyte and Meinert 2006). Anthropologists have shown that contextual factors are crucial in shaping engagement with psychopharmaceuticals, as they attribute symbolic meanings to medications (Jain and Jadhav 2009), and particularly to their side-effects (Read 2012; Chua 2018). As argued by Etkin (1992), pharmacologically defined side-effects have important symbolic value. The implications of treatment side-effects, I argue, assume particular significance by virtue of their introduction in the context of Palabek refugee settlement. The unfolding of the medications' 'social lives' in Palabek produces refugees' non-compliance by affecting perceptions of the medication's efficacy, as well as by conferring a particular symbolic meaning to psychiatric treatment, which chemical properties assume distinctive political and existential significance in their relationship with refugees' lifeworlds. Considerations of the characteristics of the context where medications are sold, prescribed, and ingested become especially relevant when considering the efficacy and use of medications prescribed in low-income settings, as these contexts are usually very different from the ones where the medication was first tested and produced (Petryna et al. 2006). Yet, these aspects remain largely overlooked in global mental health policy and practice.

Studies that analyse the impact of these dimensions on treatment pathways and engagement with mental health services are particularly needed at the current time, when global mental health policy shifts are leading to a significant expansion of psychopharmaceutical use in low-resource and refugee settings (Brauer et al. 2021; Ecks 2017; Kienzler 2019) – though, as Good (2010) pointed out, this expansion remains unevenly distributed. Scholars of psychiatry have recently pushed for a paradigm shift within the discipline, which focus they argue must move "beyond access" to psychiatric medication (Kola 2021; see also Patel and Farmer 2020). As this thesis shows, the widespread availability of psychotropic drugs in Palabek did not result in the treatment being sustained, indicating that making treatment accessible is in itself not sufficient to address mental health needs in low-resource settings. Ethnographic investigations of the 'social lives' of medications (Whyte et al. 2002), such as the one put

forward in this thesis, are essential in understanding phenomenological experiences of psychopharmaceutical treatment, as well as choices of non-compliance.

5. Notes on suffering, agency, and morality

In its attempt to show how psychocentric global mental health interventions in extremely resource-poor settings such as Palabek settlement actively 'do harm', this thesis openly engages with issues of power, marginalisation, and political abandonment. As such, it falls under what Ortner has defined 'dark anthropology', that is "anthropology that emphasizes the harsh and brutal dimensions of human experience, and the structural and historical conditions that produce them" (2016:49). Robbins (2013) has criticised anthropology's focus on suffering, arguing that the discipline should instead move beyond 'the suffering slot' and focus on an 'anthropology of the good'. Das (2015) has objected to Robbins's argument, pointing out may be simply impossible to separate an 'anthropology of suffering' and an 'anthropology of the good'. Rather, the task of ethnography is to show how the two realms coexist at any point in time; how both 'suffering' and 'the good' are fluid and contested spaces which subjects continuously and strategically navigate, with various levels of agency and ease depending on the constraints faced.

Under conditions of adversity, experiences of suffering and survival are inseparable from the roles (and failures) of institutions implicated in shaping affliction. However, a focus on suffering and on conditions of adversity does not imply the disappearance of agency. If there is at all a tension difficult to navigate for the ethnographer, it is the balanced and realistic portrayal of institutional constraints, as well as that of individual and relational agentic strategies through which people continuously establish and reframe processes of meaning-making in their social worlds. In an attempt to be able to describe in this thesis the agentic and intentional (albeit often difficult) choices that my interlocutors made, at more or less acute levels of suffering, this thesis as whole is informed by an analysis of refugees' lived experiences of displacement and mental disorder, which are more explicitly and closely examined in Chapters 7 and 8. In exploring refugees' experiences of mental health interventions and – particularly – of psychopharmaceutical treatment in displacement, my discussion is informed both by Acholi notions of affliction, disruption, as well as mental

health and illness, and from recent literature on the anthropology of morality. There are several reasons for this.

The first relates to my understanding of forms of psychological suffering and affliction experienced by my interlocutors in Palabek, and to which humanitarian interventions that I observed during my research ostensibly sought to respond. In Palabek settlement, a study of what are considered to be 'pathological' forms of suffering – both within Western nosology and Acholi systems of knowledge – cannot prescind from a recognition of the structural violence that characterises the circumstances in which refugees' lives unfold, and which are shaped by the institutional actors governing the humanitarian response through the enactment of various forms of political abandonment (see Chapter 4). This is something that I continuously show throughout the thesis; but it is also, crucially, one of the points of departure of the arguments that I put forward regarding mental health, in that I explore the phenomenological and psychological implications of such experiences of abandonment (which in Chapter 8, following Ramsay (2020), I characterise as 'temporal dispossession').

Drawing on Jenkins' (2015) crucial work on psychopharmacology, I understand psychological states of affliction of refugees in Palabek as "extraordinary conditions", a term which explicitly carries the double meaning of "conditions […] culturally defined as mental illness", as well as social, environmental, and structural conditions "constituted by social situations and forces of adversity" (ibid:1). Such "extraordinary conditions" are best understood as manifestations of "fundamental human processes" of struggle in the presence of adversity and structural obstacles (ibid:2). Underpinning the double meaning of the notion of 'extraordinary conditions' is an acknowledgement of the need for research on mental illness able to jointly consider subjective and structural aspects, which medical and psychological anthropologists have recently increasingly called for. Myers and Yarris (2019) advocate for the crucial importance of studies that centre individual experiences of psychological distress, and note that the impact of mental health diagnoses and treatment on people's lives can only be understood by situating subjective experiences of suffering within local intersubjective and sociocultural worlds (see Chapter 3).

Thus, describing refugees' experiences of displacement in Palabek as 'extraordinary conditions' allows us to understand refugees' experiences, whether characterised as mental illness or not, as positioned on a continuum from normal to pathological, rather than

biomedically categorical (see also Chapter 3). As such, in this thesis I do not draw a hard distinction between experiences of people living with what biomedical psychiatry classifies as 'common' or 'severe' mental disorders; this is not intended to suggest that there are no phenomenological differences in the experience of these conditions, but rather that it is to the 'fundamental human processes' underlying them that our attention should be turned. An analysis of experience of affliction and 'extraordinary conditions', as well as explorations of the reasons why mental health services in refugee and other low-resource settings remain largely unutilised, must necessarily depart from in-depth, qualitative explorations of people's everyday experiences of their affliction, as well as of the institutions that provide care, and of the socio-political and moral structures in which these are embedded.

By centring the perspectives and stories of displaced persons living with mental illness, I seek to focus on the "phenomenological immediacy" (Jenkins 2015:12) of individuals' narratives, whose verbal accounts of their experiences I do not seek to over-interpret, instead understanding them as carrying the "force of literality" (Biehl 2010:76). My intention here is to emphasize my informants' role not as passive recipients of mental health interventions or of psychopharmaceuticals, but rather as active agents whose actions and choices are guided by a continuous effort to maintain a sense of 'moral personhood', the "shared and culturally derived sense that one is a good and valued person" (Myers and Yarris 2019:4; Luhrmann 2001).

Following scholars such as Das (2007, 2015), Jenkins (2015), Myers (2016), Mattingly (2013, 2014), and Kleinman (2006), I contend that experiences of struggle, affliction, and mental illness in displacement can be helpfully conceptualised in moral terms, as they allow for a phenomenological discussion of individual and social lifeworlds, foregrounding people's agency in the face of adversity, and understanding the choices they make as 'moral experiments' (Mattingly 2014), agentic strategies through which people attempt to reframe a sense of integrity, intentionality, and personhood when faced with constraints to their moral possibilities (Myers and Yarris 2019). Kleinman (1997, 2006) has long made the case that what is really at stake for individuals and communities' mental health and healing – in ordinary, but especially in adverse conditions – is a sense of morality. Here, 'moral' does not refer to a higher system of values, but rather to what is locally considered to be 'good' and valuable. The achievement of a sense of 'moral personhood' represents therefore, a 'fundamental human process' (Jenkins 2015) with deep psychological and existential

implications, which 'extraordinary conditions' of mental illness and of adverse circumstances can put dangerously at stake. The fundamental human process of struggle discussed by Jenkins (2015) can be conceptualised as a continuous striving towards a 'good life' – not a fixed status, but rather an ever-evolving, continuously negotiated "project of becoming" (Myers and Yarris 2019:5) through which people make sense of their circumstances, confront challenges, and measure hopes and aspirations (Mattingly 2016).

The current 'moral turn' in anthropology (see e.g., Robbins 2016; Mattingly 2013; Desjarlais and Throop 2011) has not gone uncontested. A recent collection of essays edited by Kapferer and Gold (2018) has pointed out that the anthropology of morality risks depoliticising conditions of suffering, as well as relying on liberal, individual ideals and perspectives for analyses of people's actions, goals, and motivations, thus imposing Western (and Christian) notions of 'good' (see e.g., Holbraad 2018). Their arguments are convincing, and I tend to agree on the need to conceptually situate the 'moral turn', namely by recognising that it partly stems from a 'crisis' of the discipline generated by the current neoliberal context, in which the economisation of everyday life leaves scholars "hungry for ethics" (Kalb 2018:67).[5]

Here, however, I contend that the risk of moral perspectives functioning as an 'anti-politics machine' (Kapferer and Gold 2018) and as a form of epistemic injustice can be counteracted in two main ways. The first is through a constant and careful balance between a focus on the subjective and one on wider social categories of experience; the notion of 'extraordinary conditions' seems to me to encapsulate, and enable, this conceptual and epistemological challenge, thus effectively allowing for the *re*-politicisation of mental disorders. The second is a sincere commitment to the ethnographic and the intersubjective, and a continuous and active process of reflexivity on the part of the ethnographer (Chapter 3), to ensure that cardinal moral principles do not constitute projections of the ethnographer's own assumptions, but rather organically emerge as relevant in interlocutors' sociocultural worlds.

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[5] Questions around a similar issue had been raised around the same time by David Graeber (2016), responding to Sherry Ortner's (2016) appraisal of anthropologists' growing tendency to tackle issues of power, inequality, and oppression (a tendency which Ortner applauds, and which she explicitly identifies in the moral branch of anthropology). Commenting on what he describes as anthropology's attempts "to prove to itself it is really on the side of the underdog" (Graeber 2016:8), Graeber – an exceptionally dedicated scholar-activist himself – noted the need for reflections on the reasons underlying this shift, pointing out that as well-intentioned as these studies may be, they are also actively productive of (and inscribed in) discourse around the topics with which they are concerned. This echoes considerations, put forward by Sjaak van der Geest (2006), on the utility of reflexivity not simply for individual ethnographers, but for the discipline at large, to which I return in Chapter 3.

6. Structure of the chapters

This thesis by papers follows a scalar structure, analysing mental health interventions in Palabek refugee settlement from the policy level, to that of therapeutic means employed, and finally to that of phenomenological experiences of treatment in displacement.[6] The chapters thus differ in terms of perspective, as well as publication status and in length, which largely reflects journals' wordcount requirements.

Following this chapter, Chapter 2 provides an overview of the political, historical, and geographical context in which Palabek settlement is situated. It outlines the history of Uganda's approach(es) to refugee management and provides an in-depth description of the empirical context of Palabek refugee settlement.

Chapter 3 describes the methods employed for the research on which this thesis builds; it provides a detailed description of the fieldwork and outlines epistemological and ethical reflections around the complexities and contradictions embedded in ethnographic practice. In particular, it presents reflections on the intersubjective construction of ethnographic knowledge, as well as on power imbalances inherent to researcher-interlocutor dynamics.

In Chapter 4, I examine the role of 'psy', that is "the various institutions, practices, and discourses that constitute psychological and psychiatric expertise" (Vorhölter 2021:460) as inscribed in the wider humanitarian arena in Palabek refugee settlement. I show that in the context of the Ugandan refugee response, dominated by neoliberal and individualising logics, 'psy' discourses and interventions are employed as political devices justifying withdrawal of emergency assistance, by strategically shifting institutional responsibilities of care upon refugees themselves through the construction and enforcement of self-entrepreneurial subjectivities. This chapter, in the form presented in this thesis, has been published as an article in the journal Civil Wars. [7]

[6] Chapters 4 and 9 are presented in this thesis with an abstract, to reflect the fact that they have been already published in the same version in which they are presented here.

[7] See Torre, C. (2023). "Think Positive, Save a life"? Resilience and Mental Health Interventions as Political Abandonment in a Refugee Settlement in Northern Uganda. *Civil Wars*. https://www.tandfonline.com/doi/abs/10.1080/13698249.2023.2209485

The three following chapters explore the principal means through which mental health interventions are implemented in the settlement. Chapter 5 critically analyses the realities, failures, and social implications of a trauma-focused cognitive-behavioural therapy intervention in Palabek, showing how, with the rise of mental health as a development priority, and thus of global mental health as an international actor, these interventions establish a parallel between mental health and poverty in which the former is constructed to cause the latter. I discuss the structure and shortcomings of this therapeutic package, showing how their abstraction from the economic and social contexts in which refugees' lives unfold results in the psychiatrisation of chronic poverty. This chapter is an extended version of an article that has been published on the journal Forced Migration Review.[8]

Chapter 6 and Chapter 7 explore psychopharmaceutical prescription and use in Palabek, analysing two crucial issues surrounding these therapeutic tools – their *pervasiveness,* and their *effects.* Chapter 6 takes a momentary distance from the empirical material on which all other chapters of this thesis build and seeks to trace the historical and political processes underlying the circulation of psychopharmaceuticals in emergency settings, and particularly those through which they have come to play a prominent role in the Ugandan refugee response. Chapter 7 explores South Sudanese refugees' first-hand experiences and understandings of psychopharmacological treatment. In particular, it examines non-compliance with psychiatric medications in relation to both socio-economic factors and Acholi notions of moral and relational personhood, thus questioning notions of psychopharmaceutical efficacy in extremely resource-poor environments. Despite the two different methodologies and scales which Chapters 6 and 7 adopt, they should be read as complementing one another. I argue that an ethnographic analysis of refugees' experiences of psychotropic treatment in Palabek needs to take place against the backdrop of the wider political shifts that led to the psychopharmaceuticalization of the Ugandan refugee response.

Chapter 8 zooms in on individual experiences of distress and trajectories of mental illness. It explores the intersection of masculinities, displacement, and mental illness among Acholi men refugees in Palabek, through a temporal lens. I show that a temporality-focused perspective allows for a crucial rethinking of how refugee men experientially inhabit

[8] See Torre, C. (2021). Therapy in Uganda: A failed MHPSS approach in the face of structural issues. *Forced Migration Review*, *66*, 43–45. https://www.fmreview.org/sites/fmr/files/FMRdownloads/en/issue66/torre.pdf (Appendix 2).

displacement in three main ways. Firstly, by foregrounding socio-political processes shaping conditions of displacement; secondly, by expanding phenomenological understandings of ‘provider masculinities’ as experienced by refugee men; and, finally, by offering an explanatory model as to why the mental health care available in Palabek settlement is often perceived as unhelpful and misplaced by refugee themselves.

Chapter 9 looks at contextual factors governing engagement with therapeutic actors from a different perspective, rather reflecting on the introduction of psy-knowledge and actors in terms of pre-existing ‘therapeutic marketplaces’. It discusses the complex relationship that biomedical psychiatry in Palabek entertains with other therapeutic actors populating the healing landscape of the settlement, particularly Evangelical churches and forms of witchcraft. This chapter was published as a co-authored article in the journal of Transcultural Psychiatry [9] .

Chapter 10 concludes this thesis, proposing a temporal turn in the field of refugee mental health. From the considerations drawn at these different levels emerge my conclusions relating both to the political role of psychosocial programmes within the Ugandan humanitarian landscape, and to Acholi (and particularly Acholi men) refugees’ understandings of morality and psychological affliction in displacement.

[9] See Storer, E., & Torre, C. (2023). ‘All in good faith?’ An ethno-historical analysis of local faith actors’ involvement in the delivery of mental health interventions in northern Uganda. *Transcultural Psychiatry*, https://doi.org/10.1177/13634615221149349

Chapter 2. Palabek in historical and political context

1. Background: the South Sudanese civil conflict

Uganda currently hosts over 1.5 million refugees (UNHCR n.d.), the largest African refugee population and the third largest worldwide. Of these, around 900,000 (56.6%) originate from South Sudan and just under 500,000 (31.9%) from the Democratic Republic of Congo (DRC), and the rest from Somalia, Burundi, Ethiopia, Rwanda, Eritrea, and Sudan. As this thesis examines the refugee settlement of Palabek, where the quasi-totality (99%) of refugees originates from South Sudan (OPM and UNHCR 2023), it is necessary to provide a brief overview of the political context, which resulted in the fastest growing refugee emergency on the continent, as well as the historical cross-border and refugee-hosting relations between Uganda and South Sudan.[10]

The ongoing South Sudanese civil conflict began in 2013, two years after South Sudan gained independence. Western media has widely portrayed the civil war in clear-cut terms – often as a matter of 'tribalism' unfolding between discrete groups such as 'the Dinka' and 'the Nuer'. Scholars have argued against this simplistic narrative, which fails to grasp the complexity and multifaceted character of South Sudanese societal groups and identities, as well as the violent legacies of pre-colonial, colonial, and post-colonial governance which shape the conflict (Johnson 2014; Leonardi 2011; Rolandsen and Kindersley 2017; Ibrek 2023). The civil war is a complex and fragmented arena where political, economic, military and spiritual actors (Pendle 2020) negotiate competing interests, and its roots run deep; nuanced analyses of the conflict generally begin with South Sudan's early struggle for independence, widely regarded to have begun in 1955. At this time, regional grievances towards the abuses of the Sudanese administration sparked a civil war known as 'Anyanya I' (from the name of the guerrilla groups which led it); violently repressed by the Sudanese military, it ended in 1963. In 1972, the signing of the Addis Ababa Agreement granted Southern Sudan regional administration (though not independence); for eleven years there

[10] An in-depth analysis of the South Sudanese conflict falls beyond the scope of this thesis. For rigorous accounts of the civil war, see e.g., Pendle 2017; Rolandsen and Kindersley 2017; Craze and Marko 2022; Bimeny 2022.

was relative peace, though underlying tensions were not resolved (Rolandsen and Kindersley 2017).

From 1983 to 2005 a second civil war, widely known as 'Anyanya II', ravaged the region, this time sparked by the imposition of Sharia law on autonomous southern states by the Sudanese government (O'Byrne 2016; Hutchinson and Jok 2002). The brutality of the second Sudanese civil war cannot be overstated; characterised by widespread violence and famine, it is estimated to have caused over 2 million deaths and generated between 4 and 5 million refugees (Morrison & De Waal 2005). During this time, the Sudan People's Liberation Movement/Army (SPLM/A) emerged as the main military group fighting the Sudanese Armed Forces (SAF) for independence, and by 1990 controlled most of South Sudan. Despite the continuous changes in coalitions internal to the SPLA, which had begun splitting in multiple different factions, international pressures facilitated the signing of a Comprehensive Peace Agreement (CPA) in 2005, which granted South Sudan a high degree of autonomy. However, the years following the CPA were profoundly uncertain, characterised by widespread insecurity and "an entrenched crisis of corruption, mismanagement, and infighting within the SPLM government" (Rolandsen and Kindersley 2017:5). The state grew increasingly militarised, while provision of services from the state remained largely non-existent (Craze and Marko 2022), in what Hutchinson and Pendle have described as "a state of suspension between peace and war" (2015:416). In January 2011, following a referendum, South Sudan became independent and the world's newest nation, with SPLM/A leader Salva Kiir as President and army general Riek Machar as vice-president.

Internal divisions within the SPLM and SPLA continued to escalate. In July 2013, realising that Machar and other opponents would run against him in the upcoming 2015 elections, Kiir dismissed Machar as vice-president, along with the entire government cabinet (Johnson 2014). As tensions kept rising, in mid-December 2013 Kiir accused Machar of plotting a coup. Fighting broke out in Juba; Machar fled, while factions of the SPLA close to Kiir carried out targeted killings of Nuer residents. This led to an internal split in the army, and Machar's armed factions became to be known as SPLA-IO (In Opposition). As the fighting spread to other regions of South Sudan, Uganda sent military support to Kiir. Fighting continued through 2014 and 2015; in August 2015, a Compromise Peace Agreement was signed, but it soon resulted in failure. Conflict resumed in July 2016, with security deteriorating across the country and violence expanding to the southern states of Central and

Western Equatoria (Rolandsen and Kindersley 2017), and in 2017 the conflict expanded to Uganda-bordering Eastern Equatoria state (see Map 1, Appendix 1) (Reuters 2017).

A new peace agreement was signed in 2018, but so far has largely failed to generate change, propel a democratic transition, or improve the security situation for the millions of war-affected civilians in the country. As Craze and Marko (2022) point out, the agreement has solidified a political situation in which power is centralised and entirely held in the hands of economic, political, and military elites in Juba, while power fragmentation on the ground strategically maintains the status quo by keeping local actors weak and easily instrumentalised (see also Bimeny 2022). As a consequence, in South Sudan violence does not signal the absence or the failing of the state but has rather become a tool of management of the population by the state (Craze and Marko 2022).

The devastation caused by the South Sudanese conflict cannot be overstated. Armed factions on all sides frequently and intentionally targeted civilians, weaponized sexual violence, carried out abductions and forced recruitment, and looted and destroyed property (Ibrek 2023; Pendle 2017). A 2018 report estimates that the conflict has caused nearly 400,000 deaths (with a peak in the 2016-2017 phase of the war), and the displacement of over four million people; these include 2 million internally displaced, and 2.3 million refugees (Checchi et al. 2018). The war has also worsened pre-existing and widespread food insecurity (Human Rights Watch 2023), with at least 7.7 million people experiencing severe food insecurity and high rates of malnutrition in 2022 (OCHA 2022).

2. Histories of (forced) mobility at the Ugandan-South Sudanese border

Since July 2016, following the collapse of South Sudan’s 2015 peace agreement, fighting resumed in the country, spreading to southern areas that had been relatively spared by the conflict (IRRI 2018). In April 2017, in the midst of one of the most intense waves of violence, the village of Pajok, in Magwi County (see Map 2, Appendix 1), was attacked by the SPLA, in retaliation for the fact that the area had for years been considered sympathetic to the SPLA-IO (Madut 2020). Thousands of survivors, mostly belonging to the Acholi-speaking group, fled the area and crossed the border with Uganda. In response to the refugee

influx, the refugee settlement of Palabek was established in Lamwo District (see Maps 3 and 4, Appendix 1). [11]

The history of most regions of the African continent, as argued by Allen and Turton (1996), has been marked by continuous migration of all scales, far preceding the colonial period and the establishment of borders that took place under colonial administrations. Allen's work (1989a, 1989b, 1996) shows that oral traditions often evoke local 19th century histories of movement and flight from the violence perpetrated by invaders – ranging from slave and ivory traders to Turco-Egyptian, Belgian, Ethiopian, and British occupying forces. As pointed out by Rolandsen and Kindersley, "South Sudanese collective and individual histories often centre on migration" (2017:2). In many ways, so do Ugandan histories, and particularly those of people living in the northern region. Cross-border relations between Uganda and South Sudan have historically been a well-established reality which long preceded colonial border structures (Allen 1993, 1996; O'Byrne 2015; Leonardi 2020; Storer 2020). This is not limited to, but includes, mobility related to forced displacement. Reciprocal refugee movement has at various points in time intensified relations between South Sudanese and Ugandan groups (Harrell-Bond 1986; Kaiser 2010), resulting in what Allen and Turton describe as "[not] a simple and well-circumscribed event [but rather] an untidy process, involving multiple, and sometimes overlapping migrations in both directions (1996:7).

Over the course of the 20th Century, Uganda's history of hosting refugees and forced migrants can be traced back to the 1940s, where around seven thousand Polish refugees were re-settled in camps located in Masindi and Mukono districts (Lwanga-Lunyiigo 1993).[12] Subsequently, in the late 1950s and 1960s, Sudanese refugees fleeing the first Sudanese war entered the country; thousands of Rwandan and Zairian people followed, running from the violence and political upheaval that characterised the post-colonial period in both countries (Kaiser 2006). An opposite wave of mobility was generated by Ugandans fleeing Idi Amin's bloody regime

[11] In this chapter, I focus particularly on Acholi histories of cross-border mobility, as well as on Acholi cosmological and moral notions which are relevant for this thesis. This is made necessary by my research's focus on the Acholi language group; for a discussion of the reasons underlying this choice, see Chapter 3.

[12] During World War II, Uganda (like many British colonies in Central and Eastern Africa) also hosted a number of detainees from the Allied side. This included a number of Italian war prisoners, mostly captured by British forces in Ethiopia, Eritrea, and Somalia, in camps located in Jinja, as well as civil internees in Entebbe. Furthermore, camps near Soroti were created to host civilian internees which included Austrians, Bulgarians, Germans, Romanians, Yugoslavs, and Stateless Jews, all of whom had been brought to Uganda from Cyprus, Egypt, Palestine, and Syria (Lwanga-Lunyiigo 1993).

in the 1970s; anthropologist Barbara Harrell-Bond's (1986, 2002) seminal work on humanitarian assistance was conducted with Ugandan refugees residing in Sudan. Sudanese refugees fleeing the violence of the second Sudanese civil war fled into Uganda again in the late 1980s, as did large numbers of Congolese refugees in the 1990s. Flows of Madi-speaking Ugandan refugees returned to their homes around the same time, too (Allen 1988). In Kaiser's words: "Almost all Ugandans living in the northern border region have either been refugees themselves, or have hosted refugees, at some point in their lives" (2006:599).

The civil war that devasted northern Uganda between 1986 and 2006, waged between the rebel group Lord's Resistance Army (LRA) and Ugandan President Museveni's National Resistance Army (NRA),[13] also significantly impacted movements between South Sudan and Uganda, generating further large influxes of refugees (Allen and Vlassenroot 2010; Schomerus 2007). In 1993 the Sudanese government-backed LRA arrived in South Sudan, setting up its main military base in Eastern Equatoria State. In particular, the area of Pajok, became an LRA training ground (O'Byrne 2016). This meant that civilians were caught between a number of different armed factions, including the LRA, the Ugandan army Uganda People's Defence Force (UPDF), the SPLA (and internal factions) and the SAF. The combination of these events had profoundly disruptive effects on Sudanese border communities; amidst the continuous attacks and protracted unsafety of the region, thousands fled to Uganda, joining the thousands who had escaped when the SPLA arrived in the area in 1989 (Kaiser 2000). For those that remained, life was marked by widespread insecurity as livelihoods, infrastructure, and sources of economic activity had been destroyed by the war. As Schomerus (2008) notes, the regions of Central and Eastern Equatoria became increasingly isolated, with little assistance from international agencies and donors. While cross-border relations were maintained throughout this period, they often became a source of tension, with UPDF presence causing suspicions of land grabs and local markets being severely weakened by conflict.

What emerges is a complex landscape in which mobility trajectories, often resulting from violence and employed as strategies of survival, have historically profoundly shaped social and economic local realities. They have a significant impact on community relationships and

[13] For a comprehensive overview and in-depth analysis of the LRA conflict and its social consequences, see Allen and Vlassenroot 2010; Finnström 2008; Dolan 2009.

plays an important part in the current wave of displacement. As a result of historical cross-border mobility, South Sudanese refugees have long-standing relationships with Uganda. Indeed, as was the case elsewhere, the 1913 establishment of international boundaries between Uganda and Sudan separated a population which had historically been closely related – which Captain Richard Kelly, the colonial officer tasked with drawing the border between Uganda and South Sudan, casually acknowledged at the time (Leonardi 2020:223).

This is particularly true in the case of Acholi people which, after the international border had been drawn, found themselves split across northern Uganda and South Sudan, particularly the Magwi region of Eastern Equatoria state (Hopwood 2022:69; see Map 5, Appendix 1). As a consequence, South Sudanese Acholi refugees in Palabek share the same language and other socio-cultural practices with the residents of Lamwo District, where the settlement is located. Furthermore, as it emerged from my research, many of the Acholi residents in Palabek had been refugees in Uganda at least once before (see also O'Byrne and Ogeno 2020). Several of them had resided in Kiryandongo, during the wave of displacement that took place in the 1980s, described by anthropologist Tania Kaiser (2000, 2006); many people in their twenties and thirties, who now reside in Palabek, had been born in Uganda during that time.

With trade and intermarriage being historically common, this meant that many people have close or distant relatives and kaka (clan) members in northern Uganda and other areas of the country. It is thus necessary to historicise the current wave of displacement; while generated by recent disruptive events, it is inscribed in a long history of cross-border movement between the Ugandan and South Sudanese sides. Crucially, adopting an historical perspective in the analysis of the current wave of displacement allows to recognise the various ways in which previous experiences of displacement impact current ones.

3. Current refugee frameworks in Uganda: global and local perspectives

A regional and historical perspective on cross-border mobility between South Sudan and Uganda needs to be complemented by a discussion of the global landscape of forced migration which shapes the current Ugandan approach to refugee management. The massive influx of refugees into Uganda peaked between mid-2016 and mid-2017, when refugees

crossing the border into the country averaged at 2,800 per day (Titeca 2022; OIOS 2018). This happened at a time where the international community was facing the unprecedented increase in the scale and speed of displacement following the conflict in Syria, which resulted in 2015 in the so-called 'long summer of migration'.

In response to what was, unarguably by now, a global crisis [14] that could no longer be ignored, and certainly "partly driven by the political impulse to be seen to be doing something" (IRRI 2018:11), the UN General Assembly adopted in September 2016 the New York (NY) Declaration for Refugees and Migrants. This was little more than a statement of solidarity and acknowledgement of a shared responsibility in the management and protection of refugees, particularly in situations of protracted displacement (ibid). The goals of the NY Declaration were to be operationalised through the implementation of a Comprehensive Refugee Response Framework (CRRF) (UNHCR 2018). Several countries in the eastern and Horn regions of Africa were selected to roll out the CRRF, including Ethiopia, Djibouti, Kenya, Somalia, and Uganda, which adopted it in early 2017 (OPM 2018; Hammond et al. 2020). The CRRF is an integrated refugee model which allows refugees to move freely and to access land and social services. It is based on five mutually reinforcing pillars; (1) admissions and rights, (2) emergency response and ongoing needs, (3) resilience and self-reliance, (4) expanded solutions and (5) voluntary repatriation.

The idea of 'helping refugees help themselves' has long been a popular goal of humanitarian interventions (see e.g., Betts 2017; Ibrahim 2021; Skran and Easton-Calabria 2020). Partly, notions of self-reliance address humanitarian concerns of fostering 'dependency syndrome' [15]

[14] Here, I use the term 'crisis' to match the way in which this phenomenon was and continues to be depicted in international policy. However, I am aware of (and largely agree with) the critiques which the notion of 'crisis' in relation to displacement and forced migration has received. Scholars have argued that the depiction of waves of forced mobility under the lens of 'crisis' contribute to the depoliticization and exceptionalisation of the 'refugee condition' (e.g., Cabot and Ramsay 2021), thus lending the phenomenon to political and mediatic manipulation (e.g., Chouliaraki and Stolic 2017). In the context of the 2015 'long summer of migration' in Europe, for example, adopting a 'crisis' paradigm in the understanding of displacement and forced migration trends shifted attention from the fact that the phenomena are largely manufactured by hyper-securitised and hostile border regimes in the Global North (e.g., Kasparek 2016), while at the same time concealing their use as currency in political negotiations, most recently for example between the EU, Greece, and Türkiye (Tazzioli 2019).

[15] It should be noted that the notion of 'dependency syndrome' has been heavily critiqued, and its 'myth' largely debunked. Scholars have shown that ideas of aid dependency among refugee populations inaccurately portray the intricate social and agentic strategies that people employ to survive in conditions of adversity, as well as overestimate the extent to which aid provision effectively reaches populations (see e.g., Allen and Turton 1996; Kibreab 1993; Easton-Calabria and Omata 2018). Ideas of self-reliance deployed to contrast and

among refugees; they also emerge from a pragmatic and long-term perspective on forced displacement. Following the large-scale migration flows that characterized the 1960s and 1970s in the Middle East and Asia, and especially Africa in the 1980s, emergency response to forced migration proliferated in the form of 'refugee warehousing' in the Global South (Hyndman and Giles 2011). This entailed refugees being confined in camps in neighbouring countries to their original ones, often with restricted mobility; allegedly a temporary measure, 'warehousing' was in reality often far from a short-term solution, and frequently translated to people waiting for several years for repatriation to become a viable option (Ilcan and Rygiel 2015; Agier 2018). This model was heavily criticised: for example, Malkki (1995) discussed the 'refugee camp' as a 'technology of power', noting its role in the construction of a dominant discourse depicting refugees as racialized, often feminized, undifferentiated, and voiceless victims (Johnson 2011; Malkki 1996), whose survival entirely depended on humanitarian aid distributed within the camps.

In the global landscape of refugee hosting countries, Uganda stands out for being one of the few countries to have invested in a different approach. In Uganda, South Sudanese refugees are granted *prima facie* refugee status upon proving their citizenship at one of the border points (UNHCR 2019). For over three decades, the emergency has been managed primarily by the Office of the Prime Minister (OPM) of Uganda. UNHCR retains a presence but does not directly administer the refugee response, instead operating through implementing partners, which include both international and Ugandan NGOs (see e.g., Kaiser 2000).

Uganda's refugee policies have long centred around the notion of refugees' achievement of economic independence, and the Self-Reliance Strategy (SRS) was introduced in the country in 1999 (Kaiser 2000; Hovil and Werker 2001). One of the guiding principles of the SRS is the Settlement Transformative Agenda (STA), formally introduced by the Government of Uganda in 2015 (UNHCR 2018), but effectively in operation since the mid-1990s (Kaiser 2000). The STA proposes an ambitious transformative agenda aimed at the integration of refugees within host communities; under this framework, refugees are settled within or alongside host communities, where they are allocated a plot of land which they are expected to cultivate to achieve independence from humanitarian assistance and a sustainable source of

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prevent dependency, furthermore, have been pointed out to disregard the value of mutual assistance found in refugee social networks (Easton-Calabria and Herson 2020).

income (Krause 2016; Schiltz et al. 2019). Refugees are also granted the right to work and to move freely around the country and have free access to education and health services funded by UNHCR.

The adoption of the settlement model, in Uganda and elsewhere, is the result of a shift in the conceptualisation of refugee camps which began in the 1980s, in reaction to criticisms claiming that the encampment approach to refugee management was detrimental to communities' livelihoods, ignoring refugees' wishes and capacity to self-determine and provide for themselves (e.g., Harrell-Bond 1986), and fostering various forms of 'dependency syndrome' (Easton-Calabria and Omata 2018; Slaughter et al. 2017). Camps went from being constructed as temporary setting of 'care and maintenance', where the management of refugees was centralised and entirely in the hands of humanitarian emergency governance, to spaces of improvement and empowerment, where refugees could achieve independence from humanitarian assistance (Duffield 2013; Ilcan and Rygiel 2015). The result of this shift was a form of humanitarianism which main aim was no longer limited to the provision of food and shelter, instead increasingly focusing on affected individuals' and communities' existing capacity to recover from crisis through the fostering and mobilisation of their own resilience (Oliver and Boyle 2019), which I expand on in Chapter 4.

The settlement model provided a chance to introduce development-oriented interventions in refugee settings in the Global South. This approach is generally framed as aimed at benefitting both refugees and host communities, thus opening pathways towards a 'durable solution' to growing refugee influxes. By adopting this framework, Uganda's approach to forced migration can – at least on paper – certainly be considered more progressive than hyper-securitised and hostile border politics implemented over the past several decades by the vast majority of countries in the Global North (Hansen 2018; Tazzioli 2028). The implementation of SRS granted Uganda a precious reputation as an example of successful refugee management through self-reliance (Hovil 2007), and the country has often been highly praised by international media and organisations as a model for refugee integration for its allegedly progressive, human rights and development-oriented refugee policies (Clements et al. 2016; Betts et al. 2014). Coupled with the poverty reduction reforms that President Yoweri Museveni implemented, it has helped Uganda consolidate a precious reputation as a 'donor darling', thus guaranteeing a steady flows of funding streams in the country (Titeca 2022).

As Kigozi (2017) shows, this positive coverage was largely spurred by a series of studies (see e.g., Betts et al. 2017; Betts et al. 2014) which had mostly focused on the southern settlements of Nakivale and Kyangwali (see Map 4, Appendix 1), which together host less than one fifth of the total refugee population in Uganda, and where refugees mostly originate from DRC, Somalia, Burundi, and Rwanda. These studies are far from representative of refugees' real circumstances in Uganda, particularly as they pre-date the large influx of South Sudanese refugees. Despite this arguably significant inaccuracy, Uganda's approach to refugee management kept attracting praise and enthusiasm, largely motivated by international actors and donors' stake in the strategy being proven successful, as it served the double purpose of containing the cost of displacement while keeping huge numbers of refugees far from Western countries (Oliver and Boyle 2019; IRRI 2018; Titeca 2022). Uganda's willingness to implement what was at the time an innovative and in many ways experimental approach to refugee management consolidated the image of the country as a 'testing ground' of humanitarian interventions (see Chapter 6).

Scholars and activists have long pointed out that the reality of self-reliance strategies in Uganda is decisively bleak, and very far from the success story depicted by international actors and media; that Uganda is the only refugee-hosting country to have a dedicated 'Suicide Dashboard' on UNHCR and other humanitarian databases (see e.g., UNHCR 2022) should be read as a powerful indicator that the country is, indeed, not the haven for refugees that policy hubs located in the Global North would like to depict. In addition to criticising the humanitarian conditions in the settlements (e.g., Hovil and Werker 2001), authors have pointed out the lack of basic needs as one of the main shortcomings of SRS, arguing that in the absence of sufficient resources refugees' circumstances allow at best for survival, while self-reliance remains impossible to achieve (Kaiser 2006; Zakaryan 2018; Krause 2016; Dryer-Peterson and Hovil 2004). Food rations are worryingly inadequate to meet the needs of the overwhelming majority of refugees (Oliver and Ilcan 2018); cash flow is generally so limited that often people resort to selling a significant share of their limited food supply to grind the grains they receive as food aid, and to purchase essential items, such as soap, medicines (often lacking at the underfunded Health Centres), and school supplies for children (see e.g., Ilcan et al. 2015; O'Connor 2017; Schiltz et al. 2019).

In particular, the settlement model has been pointed out as largely responsible for SRS' pitfalls (Krause and Gato 2017; Kaiser 2006). The model follows a neoliberal approach to emergency assistance, which configures settlements as spaces of development and self-entrepreneurship (Ilcan and Rygiel 2015; Krause and Schmidt 2020), at the same time dictating that only refugees who reside within them are eligible to receive material assistance through UNHCR and its implementing partners. While a few people manage to move outside the settlements by relying on pre-existing networks in Uganda, often originating from previous experiences of displacement, for the vast majority of refugees this is not an option. As a result, most refugees reside in the settlements for several years, and often for the whole length of their displacement in Uganda (IRRI 2015; Bohnet and Schmitz-Pranghe 2019). At present, only about 8 per cent of refugees have chosen to settle in urban and peri-urban locations, mostly around the capital Kampala, while the vast majority still resides within the country's thirty settlements, spread around twelve refugee-hosting districts (OPM 2021).

Refugee settlements are often located in rural and impoverished areas, from where freedom of movement is often restricted through bureaucratic challenges and largely discretionary behaviour from Ugandan government officials (RLP 2007; Kaiser 2006). For most people, this means that subsistence farming and small-scale market activities constitute the main route to self-reliance (Bohnet and Schmitz-Pranghe 2019; Oliver and Boyle 2019). This wrongly assumes that all refugees have the skills and interest to be farmers (Krause 2016) and ignores that the income-generating power of such activities is so small and unpredictable that refugees are often left "impoverished and dependent" (RLP 2007:1) upon constantly decreasing humanitarian assistance (IRRI 2018). This significantly limits the achievement of self-sufficiency, to the point where SRS has been argued to not only not address, but ultimately work against refugees' protection and wellbeing needs (Krause 2016; Schiltz et al. 2019; Hovil 2007; Oliver and Boyle 2019). As Kaiser points out, settlements have done little more than replace the much criticised 'care and maintenance' model of refugee encampment with one which at best allows for 'bare maintenance' (2006:615).

If SRS and STA strategies have so far proved inadequate to allow refugees to reach economic self-sufficiency, they have become a source of severe tensions and anxieties for the host communities from which the Government of Uganda has appropriated (ostensibly only temporarily, see IRRI 2018) unused land to establish the settlements, with the promise of new infrastructure and development programmes in exchange. While these promises have largely

failed to materialise, Ugandans living close to settlements now fear ever being able to get their land back (IRRI 2019), and thus look with suspicion at refugees, who they often perceive as receiving the entirety of the assistance – whereas 30% of the assistance is supposed to be directly channelled in development projects aimed at host communities (UNHCR 2019).

The possibility of social integration of refugees is also complicated by the intense competition for natural resources. The arrival of large numbers of refugees in already economically deprived areas – such as those located in the north of the country – has caused significant tensions particularly around the cutting of trees, from which both refugees and host communities derive timber, used for construction, and firewood, the cheapest available fuel for cooking (Miura and Tabata 2022; Gumisiriza 2018). Compounded by the illegal trade of charcoal in northern Uganda (Branch et al. 2022), rates of forest degradation and depletion of natural resources are increasingly noticeable problems in the region, and particularly acute around refugee settlements (World Bank and FAO 2019). People regularly have to venture outside to look for firewood; women report being violently beaten or sexually assaulted by members of the host communities (IRRI 2019). Ever-rising tensions around natural resources often explode in violence and, in one case, resulted in the killing of at least ten refugees in Rhino settlement, in Madi-Okollo district in West Nile (The Observer Uganda 2020).

An overview of the current shortcomings of the SRS in Uganda would be incomplete and inaccurate without a discussion of two factors at the root of the chronic scarcity of resources that has for decades characterised the country's refugee response. Firstly, the South Sudanese refugee response is one of the most underfunded emergencies in the world (UNHCHR 2021). Partly, this is due to its relatively limited 'policy relevance' (Omata 2020) on the global stage, which in recent years has been largely occupied by emergencies with more direct implications for Euro-American politics. The widespread corruption endemic to the Ugandan refugee response (and, arguably, to most state ad non-state organizations in the country) contributes significantly to shrinking the already limited funding available. While corruption at all scales is in many ways an open secret within the country's humanitarian apparatus, in late 2018 a UN audit denounced that over 214 million dollars had been unlawfully appropriated by OPM and UNHCR officials, mostly through declaring inflated refugee figures (OIOS 2018). The news made global headlines, sparking outrage among donors, leading many of them to freeze funding streams for several months (Titeca 2022). Despite

international actors decrying that Uganda had gone from “a model of refugee response to a cautionary tale” (Green 2018), little accountability has taken place, while new evidence that corruption is alive and well in the Ugandan humanitarian response regularly emerge (Titeca 2023).

Despite the evident failings of SRS, Uganda maintained its guiding principles under subsequent refugee policies – the 2003 Development Assistance for Refugee Hosting Areas (DAR), the 2017 Refugee and Host Population Empowerment (ReHOPE) and, most recently, the CRRF (IRRI 2018). Over time, the settlement model has remained essentially unchanged, as have its pitfalls; in the rest of this chapter, I provide an overview of how these issues, as well as the legacies of previous experiences of displacement, manifest in Palabek refugee settlement.

4. The site

4.1 Road to Palabek

Throughout my fieldwork I rented a home in Gulu, the administrative capital and main urban centre of northern Uganda, to which I returned every so often from the settlement. Having a base in Gulu allowed me to benefit from the lively research community active in northern Uganda; furthermore, exiting and re-entering the settlement relatively regularly allowed me to situate the settlement within the rapid political and social mutations which northern Uganda was undergoing at the time. At the time, Gulu was about to switch status from Town to City, and there was a palpable hopefulness that things were finally improving. Practically everywhere in the town centre, the roads were undergoing massive improvement works; new and ambitious businesses were opening, and young university graduates were moving from Kampala to test the ground for job opportunities. While resources were unevenly distributed and life certainly remained difficult for many, the bustling urban rhythms of Gulu provided a sobering contrast to the socio-economic and existential realities of life in Lamwo District, and especially of Palabek settlement.

The 117 kilometres-long road to the settlement allowed for the regular observation of other, arguably more sinister changes taking place in northern Uganda between 2019 and 2020.

Among the tall grass and a forest of palm trees, my friend Tony would drive me on his motorbike through the small centres of Kabedopong, Bungatira, and Lukodi, where the memorial to the victims of the infamous LRA massacre that took place there in 2004 could be easily spotted from the road.[16] We would reach Patiko, where the fort of the colonial officer Samuel Baker had once been; though only rocks remained, it had been turned into a popular tourist attraction and was now locally referred to as 'Fort Patiko'. Then, we would pass the small but lively Palaro trading centre, where huge trucks stopped overnight on the way to Kampala, Kitgum, or Lira. Some carried cotton, which filled the air in unlikely snowstorms.

From Palaro to Palabek, the road revealed a picture of northern Uganda far less hopeful than the one conveyed by the urban and vibrant atmosphere in Gulu, or the tranquil one of surrounding villages. Trip after trip, Tony and I witnessed the environmental devastation caused by the illegal trade of charcoal and timber. We commented on the rates of deforestation, pointing out to one another wide areas that just the previous week had been covered in trees and that now were completely empty. Tony shook his head under the heavy helmet he wore on the long rides. "It is terrible", he muttered. "These people are destroying their land". And yet, the sacks of charcoal displayed for sale across the road were priced at half what they were in Gulu, and a third of their cost in Kampala; slightly embarrassed, Tony explained that on the way back, he sometimes bought some for himself. We encountered dozens of trucks loaded with charcoal, often filled way beyond capacity and dangerously prone to overturning; their weight damaged the small countryside roads, which the lorries took to avoid detection by authorities.[17]

We drove by the vast army barracks and training grounds, where since mid 2019 thousands of newly recruited soldiers had been deployed; we witnessed their numbers growing at every journey, and watched them practicing marching, running, assembling and presenting weapons. At this point in the trip, I could often sense Tony's body stiffen in front of me; he accelerated, focused on getting over the training grounds as quickly as possible. He did not like passing the barracks, he explained. The presence of the soldiers worried people in Gulu, and led to whispered questions and anxious silences in conversations; with violence ongoing in South Sudan and rising tensions with Rwanda, did that mean that war may be coming back

[16] For a discussion of the Lukodi massacre, see e.g., JRP 2011.
[17] For a discussion of the politics of charcoal trade in Uganda, see e.g., Branch and Martiniello 2018.

to the region soon? [18] Tony and I discussed these issues on our usual stop before reaching Palabek settlement, sitting in the shade of a bridge across the river Aswa – the same river which, had we followed it for about one hundred kilometres north, would have led us across the border, and straight to Pajok. The purpose of our trips coloured this simple geographical fact with an uneasy irony, and the war in South Sudan felt unsettlingly close. Around us, groups of children would take turns fishing with short spears, or dared each other to swim against the current, quite powerful in rainy season; they looked focused and proud at every new rock they conquered by beating the stream.

At every journey, the devastating reality of mass deforestation and the increasing militarisation of the country emerged more clearly. It was a remarkable, if disquieting trip, which I often thought of as a journey through some of the events that most shaped and continue to shape northern Uganda: the colonial past and the civil conflict, which for so long defined the region, and whose consequences arguably continue doing so; and the hints of rising authoritarianism and environmental devastation, so eerily evocative of Uganda's present and possible futures. Upon arrival in Palabek, all of these features remained acutely visible, and hauntingly present in the entanglements between Uganda's own history and the global migration crisis.

4.2 The settlement

Located about seventy kilometres from the border with South Sudan, Palabek settlement extends over a fifty square kilometres area over three sub-counties in Lamwo District – Palabek Gem, Palabek Ogili, and Palabek Kal. During my fieldwork, the settlement was home to about 54,000 people belonging to more than fifty different ethnic groups; among these, the Acholi group retained the biggest presence, accounting for roughly 43 per cent of the whole population (UNHCR, personal communication, 21 October 2019). While initially this had facilitated rapport between the refugee and host communities, by the time I began my fieldwork relationships had grown more tense. Host communities were growing increasingly

[18] In early 2019, Uganda accused the Rwandan army of killing of two people on Ugandan soil, thus violating the country's territorial integrity. Rwanda responded by denying the accusations and closing its border with Uganda. Diplomatic relations between the two countries became extremely tense, and for a while the possibility of war seemed worryingly realistic to both local people and international observers. After a nearly three-year long stalemate, in late January 2022 tensions eased and the border was finally reopened (see e.g., Daily Monitor 2020; Al Jazeera 2019; Daily Monitor 2022).

hostile towards refugees, who often described feeling threatened and unsafe (‘pe bedo agonya’ in Acholi), particularly when living in close proximity with the host community. Trees are scarce in the settlement; the few that remained were easy to spot. One NGO had marked them with red paint, indicating that they should not be cut, but this sign went often ignored.

At the time of research, Palabek settlement was divided in eight zones (Zone 1 through 7, with Zone 5 divided in 5a and 5b), all of which are divided in varying amounts of smaller Blocks. Each Block and Zones has an elected representative, known as Refugee Welfare Committee (RWC) 1 and 2, respectively. The highest level of refugee representation is the RWC 3, the Camp Chairman. RWCs are intended to represent a “non-political mirror of the Local Council [LC] system” (Vancluysen and Ingelaere 2020:307), and their function is similar to the latter; like LCs, RWCs are often consulted to settle disputes of different kinds – ranging from arguments between neighbours, to theft, and domestic and sexual violence cases within the settlement, and to disputes with host communities. The settlement had expanded outwardly from Zone 1, and the first arrivals – the quasi-totality of whom were Acholi – had settled in Zones 1-4. Zones 5, 6, and 7 were instead mostly populated by Lotuko, Langi, and Nuer refugees. The difference between Zones where people had been settled for a while, and those were most of refugees were newcomers, was often stark. While in Zones 1-4 mudbrick huts had been built in almost every compound, in the others it was far more common to spot UNHCR-marked tarpaulin being used as shelter. The further one travelled into the settlement from Base Camp, a fenced area located at the main entrance which hosted UNHCR, OPM, and a few NGOs’ offices, the more the place looked overcrowded, and infrastructure absent or already decaying.

This was particularly evident in Zone 5, one of the most remote in Palabek settlement. At the time of research, it was both the area undergoing the fastest expansion in Palabek, with most new arrivals being settled there, and the one where the defunding of the refugee emergency could be felt more acutely. This translated into a general lack of new infrastructure for the recently arrived refugees, as well as in Zone 5 being less targeted by NGOs, which often concentrated interventions in areas of the settlement which were easier or cheaper to reach. This significantly contributed to the pervasive feeling of stigma perceived by residents of Zone 5, who often felt discriminated by the humanitarian system for belonging to other

groups than the Acholi speaking one. In turn, this often led to tension between different language groups in the settlement.

At times, this led to outbursts of violence, but there was little hope among refugees that justice could be achieved in those cases. Police stationed in the settlement (as in the rest of Uganda) was known to be corrupt and unreliable, and RWC's role, as noted by Ogeno and O'Byrne (2018), is largely performative. While their election had been portrayed by the Ugandan government as way to 'empower' refugees and to establish a productive dialogue between them and the humanitarian apparatus, refugee representatives have very little power to effect change, particularly when in dialogue with OPM, UNHCR, and other institutional officials.

Life in Palabek settlement is heavily shaped by the pitfalls of SRS. Lamwo District is one of the least developed areas in Uganda, where between 50 and 75 per cent of people are estimated to live in poverty (World Bank 2018) and which still suffers heavy social and economic consequences of the brutal LRA conflict (Bimeny 2022). As such, refugees living in Palabek are unable to participate in the plethora of economic and trading activities that characterises other areas of the country, while the stagnating economy of Lamwo District severely restricts even occasional employment opportunities. Meanwhile, the poor quality of the land limits the possibility of relying on cultivation. For most refugees living in Palabek settlement, therefore, the possibility of achieving self-reliance and independence from humanitarian assistance is a distant one. This came as a harsh surprise to many, particularly to those who had been part of a huge wave of Sudanese refugees that fled to northern Uganda during the 1990s and that for several years resided on land gazetted by the Ugandan government for refugee use (Kaiser 2000). As an Acholi refugee leader commented:

> *"Things were different back then. For us, we were in Bweyale, Kiryandongo camp. We had sacks of food in the house, we didn't even have to wait for World Food Programme. […] But now… how can you expect for a family to be able to survive and feed themselves on a plot that is 30x30? You cannot compare with today, with this settlement here."*

Previous experiences of displacement are often nostalgically evoked in conversation, and statements like the one quoted above are common in Palabek. While people may tend to

romanticise the past, there are undeniable elements of truth to these accounts. Today, each refugee household in Uganda is allocated a plot of land of 30 by 30 metres, while in the 1990s, most people were assigned between one and ten acres of arable land, depending on the time of arrival and family size (Kaboggoza 2022). Even in the worst-case scenario, this amounted to around 4.5 times the amount of land available to households today. While certainly fraught with systemic challenges (e.g., Kaiser 2000, 2006), circumstances at the time were arguably more favourable to the achievement of self-reliance than they are today. The global landscape of forced migration had also drastically changed since the 1990s; at the time, a relatively high number of South Sudanese refugees had been relocated to New Zealand, Kenya, or Australia (O'Byrne 2022). Since then, however, hyper-securitization of borders, which had skyrocketed with the US-waged 'war on terror' of the early 2000s (Cretney 2014), meant that resettlement opportunities had become virtually non-existent (Hansen 2018). Often, for my interlocutors this realisation was accompanied by anguish, and by a sense of hopelessness; there was, effectively, nowhere else to go.

The lack of basic resources and widespread food insecurity acutely characterise the experience of most people. In Palabek settlement, specifically, residents report that monthly food rations only last about twenty days. During my fieldwork, "The food is not enough" ('Cam pe oromo' or 'Cam nok' in Acholi) was a statement heard everywhere – ranging from organisational meetings to community gatherings, everyday family interactions, and clinical settings. A 2018 survey indicates that for most refugees, the only option is to reduce food consumption, and it is common for refugees to only consume one meal per day, to stretch food assistance over the entire month (Government of Uganda et al. 2018; Torre 2023), and to adopt a combination of different 'negative' coping strategies (i.e., strategies which tend to diminish households' abilities to withstand new shocks in the long term). Mostly, these consist of spending savings (23.4% of households), regularly borrowing money or food items for survival (35.9% of households), begging for money or food (35.7% of households), selling assets that people would not have normally sold such as food aid or personal belongings (19.6%), and consuming seed stock which was being saved for the next season (15.1%). Only 6.7% of households reported not having to use any negative coping strategies. Palabek also stands out for having the highest rate of 'borrowing' and the second highest rate of 'begging' among settlements in the country – second only to urban refugees in the capital Kampala (Government of Uganda et al. 2018).

4.3 Fear and suspicion as embodied affects in Palabek

In the context of lived experiences of displacement characterised by chronic scarcity and precarity, a keen awareness of pervasive corruption meant that wariness and suspicion of the humanitarian apparatus in Palabek (and of Uganda as a whole) were prevalent among refugees. Sarah Ahmed (2014)'s impactful work has shown that emotions are less to be conceptualised as psychological states, and more as cultural practices. As such, they are intersubjectively generated and performed, and interpreted; and indeed, these emotions were continuously reproduced in social interaction. This was evident in the frequent accounts circulating about NGOs' malfeasance, as well as in rumours surrounding the possibility of institutions intentionally harming refugees, such as those which frequently spread around poisoning taking place at the Health Centres (see Chapter 8) Considerations echoing feelings of mistrust, such as *"The* [Ugandan] *government is just eating money*", and "*They* [NGOs and OPM] *don't mind about refugees"* were common, particularly when new events occurred that exacerbated everyday hardship, such as delays in food distributions, announcements of aid cuts, unavailability of medications at the settlements' Health Centres. Feelings of suspicion coloured most interactions between refugees and NGOs. One woman explained: *"Here they are discriminating people. Sometimes NGOs will tell the camp chairman that they are giving things to orphans, but they are just giving things to their own people"*. As stated by one Acholi-speaking man: *"We are refugees; we wait for people [NGOs] that never come"*, poignantly encapsulating the affective experience of institutional abandonment (Chapter 4). One refugee leader reflected on the frustration resulting from the acutely perceived power imbalance:

> *"You feel like you are being used. You realise that these people…they are not even educated, yet they are in charge of you, like we are just pawns. Meanwhile they are making so much money out of refugees…it's a business for them".*

This sense was heightened every time the shortcomings of the humanitarian response became apparent – in the case of food cuts, delays in distribution, absence of medication, all of which the institutions governing the emergency in Palabek communicated with little to no warning. Much like the ways in which the Ugandan state operates through what Tapscott (2021) has termed 'arbitrary governance', based on the strategic use of unpredictability (see Chapter 7), the humanitarian apparatus in Palabek governs through a strategy of what Janmyr has

referred to as “deliberate confusion” (2014:212). This has been observed elsewhere, too; the employment of confusion and unpredictability as governance tactics in refugee settings has been pointed out by Stel (2020) in Lebanon’s management of forced migration, and by Tazzioli (2020) in Italy’s approach to undocumented migrants crossing the Alps.

Previous experiences of displacement in Uganda also shaped widespread feelings of insecurity among refugees in Palabek. While many people had fled into Uganda in the 1990s, when the LRA established its main military base in South Sudan, this often did not mean being able to escape the violence of the conflict. Instead of finding shelter, many had found themselves trapped in areas of northern Uganda where the security situation had deteriorated, and where close to two million Acholi people had been forced by the government into internal displacement camps (IDPs). The camps were frequently attacked and looted by the LRA (see e.g., Dolan 2009; Verdirame and Harrell-Bond 2005). Particularly infamous are two instances, in 1996 and 2002, in which the IDP camp of Achol-Pii, in Agago District, was attacked by the LRA attack; in both instances, dozens were killed (Kaiser 2006). Several of my interlocutors in Palabek had survived one or both the attacks on Achol-Pii, which had resulted in mass relocation to other IDP camps in the region. The horrors they had witnessed while ostensibly being under Ugandan and international protection had resulted in a profound sense of fear and suspicion, which influenced their experience of displacement in Palabek.

And yet, fear and suspicion did not only originate from the failures (intentional or unintentional, present or past) of Ugandan institutions, nor from tensions arising with the host communities; it came from social and political dynamics internal to the refugee population, too. The proximity of the border with South Sudan meant that incidents related to the war were frequent. SPLA-IO rebels hiding in South Sudan were known to return to the settlement around Christmas and other holidays to spend time with their families; this generated widespread disquiet, and for days the affective atmosphere (Anderson 2009) of Palabek would feel more tense than usual, and could be described as dominated by a sense of trepidation and foreboding, similarly to what Jefferson and Buch Segal (2019) have described in Palestinian refugee camps.

Often, residents would wake up to rumours that guns had been found in the settlement, evoking the alarming possibility that SPLA or SPLA-IO soldiers may be about to bring the fighting to Palabek; some, who had fled South Sudan fearing repercussions after refusing to

join SPLA-IO, expressed profound fears of being abducted and brought back to South Sudan. On food distribution days, OPM representatives, police officers and UPDF soldiers often confiscated sacks of maize or beans upon spotting people loading them on lorries, ostensibly to avoid refugees bringing food provisions to the rebels in South Sudan, at the same time providing a reminder of the deeply political nature of the refugee response. Large tanks could be often seen near the Base Camp; at times, their tracks could be spotted in the morning on the settlement's dirt roads, indicating that they had passed through the settlement overnight. Nobody seemed to know the reason; speculations turned into rumours, travelling fast across the settlement.

As Coker (2004) noted in her study of "travelling pains" among South Sudanese refugees in Cairo, in Palabek the distress caused by these troubled circumstances manifested on bodies; insomnia, stomach ulcers, and chest pain were among the most common somatic complaints that led refugees to consult doctors. Das has described how "The fragility of the social becomes embedded in a temporality of anticipation since one ceases to trust that context is in place. The affect produced on the registers of the virtual and the potential, of fear that is real, but not necessarily actualized in events, comes to constitute the ecology of fear in everyday life'' (2007:9). Despite the variety of agentic strategies that most people are able to employ to survive and find, for many refugees everyday life in Palabek is inscribed in an 'ecology of fear' characterised by frequent and embodied experiences of suspicion, uncertainty, and insecurity, heavily shaped by scarcity of resources, and compounded by the complex – and at times hostile – political landscape in which the settlement is situated, and where people's lives unfold. For Acholi refugees, these feelings were also exacerbated by the continuous arrival in the settlement of newcomers from other language groups; while when the settlement had been established the Acholi group had been the main one, over time the proportions changed considerably, and as of April 2023 represented only 37% of the population of Palabek settlement (UNHCR, May 2023 personal communication). This was met by Acholi people with widespread anxieties and suspicion, increasing the perceived sense of disruption of the social and moral order.

It is essential, however, to note that despite these structural challenges and forms of political and institutional abandonment (Chapter 4), which often generate experiences of temporal suspension (Chapter 8), Palabek refugee settlement is anything but a motionless or uneventful space. People display remarkable levels of resourcefulness in actively caring for their loved

ones; they relentlessly explore fleeting and precarious job opportunities, send their children to school, organise and partake in celebrations, build and decorate their homes, go to church and to dances, greet each other, gossip or discuss politics, find time for friends, argue, fall in love and start families. Babies are born and welcomed with joy; the dead are mourned collectively, for days, with tacit but telling individual and communal acts of presence and compassion. Life does continue, in all its relational complexities. The rhythms of the settlement are similar to the bimodal seasonal ones of the rest of the region; in rainy season gardens flourish with greens, and the blooming vegetation temporarily makes up for the lack of trees. The dry season air is filled with the smoke of burnt grass to prepare land for cultivation, opening up one's vi and revealing people busy making bricks and thatched grass roofs. Construction is fast and ever-present (Wainman et al. 2022), as are forms of small-scale trade. The main trading centre of the settlement, which refugees call 'Jerusalem', has a small food market; over twenty small businesses operate there, including barbershops, bicycle repair shops, and at least two bars which show movies and football games, turning into lively dance halls several nights a week. A multitude of restaurants, mostly catering to NGO workers, populate the entrance of the settlement, widely referred to as 'Reception'. A monthly non-food market is held here or in nearby areas outside of the settlement. This was a much anticipated event, attracting hundreds of both refugees and Ugandan citizens. On the auction morning, crowds of people from all Zones of the settlement made their way towards it; many carried food to sell to buy clothes and other items.

5. A brief overview of Acholi moral notions of personhood

The study of mental health interventions in displacement, with which this thesis is concerned, must necessarily be grounded in an understanding of the ways in which crisis and disruption are experienced and navigated by South Sudanese refugees, and particularly by Acholi-speaking individuals and groups. In order to do so, here I provide an overview of moral concepts particularly relevant in of Acholi lifeworlds.

As an overarching principle, Acholi lifeworlds are centred around maintaining harmonious relations with the environment and all social entities – physical and spiritual, living and dead (Finnström 2008; p'Bitek 1986; Porter 2013, 2016). This balance is integral to the notion of

"social harmony", put forward by anthropologist Holly Porter in her deeply insightful research on rape and social repair in Acholi northern Uganda. Porter describes social harmony as "an idea of cosmological equilibrium, and social balance of power and moral order" (Porter 2016:3) around the preservation or restoration of which every social and moral decision revolves. Porter is careful to note that social harmony should not be understood as a coherent set of beliefs, universally shared, uniformly interpreted, or devoid of conflict. Rather, it is an ideal subject to the fluidity and complexities of intersubjective experiences; as such, it is continuously negotiated, transgressed, and redefined in people's everyday realities. Indeed, ethnographic accounts show that decisions around crucial aspects of daily and intersubjective life in Acholi, whether about land (Hopwood 2022; Girling 2019; p'Bitek 1972), justice (Porter 2013, 2016), or health (Williams 2019; Meinert and Whyte 2017, 2020), are at once always related to ideas of moral order and inevitably fraught with conflict. It is something towards which communities and individuals continuously strive, but which is impossible to fully achieve or maintain. Meanwhile, deviation from the norm and the consequent disruption of 'social harmony' is heavily sanctioned, while resolution often involves the reproduction of dynamics of exclusion, marginalisation, and even violence (Allen 1989; Porter 2016; Storer 2020; Storer and Torre 2023).

The notion of 'social harmony' is essential to understand that, in Acholi lifeworlds, the achievement of 'good existence' is a fundamentally social and cosmological, rather than simply individual, process. The idea of good existence can be rendered in Acholi through the notions of 'bed ma ber', and through the expression 'piny ma ber' – literally 'good surroundings' (Porter 2013).[19] As Finnström (2008) has described, circumstances of hardship and profound disruption during the LRA war were widely described in Acholi as 'piny ma rac', 'bad surroundings'. In his collection "The Artist and the Ruler: Essays on Art, Culture, and Values", Acholi scholar and poet Okot p'Bitek has described a 'good existence' as "when things are normal, the society thriving, facing and overcoming crises" (1986:27). The notion of 'ber' ('good'), p'Bitek notes, is at the core of Acholi lifeworlds; it is an intricate concept, both deeply existential and fundamentally social (ibid. 1986). Crucially, just like Porter's social harmony does not exclude conflict, p'Bitek's consideration is that notions of 'good' do not entail the absence of crisis, conflict, and uncertainty; rather, these are an essential (and

[19] Throughout this thesis, I refrain from italicising words belonging to the Acholi language, in an attempt to avoid the textual reproduction of (neo)colonial forms of epistemic injustice. I thank Ryan O'Byrne for making me reflect on the ideological implications of visual and linguistic choices in this regard.

inescapable) element of life, and part of the latter is the reckoning with challenges of various kinds – be they social, moral, economic, or spiritual problems.

My sense is that this stance which regards the 'dark' aspects of life (e.g., crisis, hardship, and disruption) as 'normal' emerges both in Acholi, and in Acholi English, connotations of the notion of 'struggle', conveyed by the verb 'yelle' in Acholi. My impression is that in Acholi, the verb 'yelle' has a slightly different meaning than it does in British (or American) English, where 'struggling to do something' generally evokes frustration and unwanted difficulties, characterising something as 'difficult' as opposed to 'easy' or 'straightforward'. While the Acholi verb 'yelle' suggests hardship as well, it is often used to indicate the *processual* nature of achieving or overcoming something that is considered difficult. The verb 'yelle', therefore, does not exactly convey the notion of 'struggling to do something', but rather that of 'struggling *towards* something'. For example, the sentence 'Ayelle ka pwonyo' does not simply translate to "I am struggling to learn" but is rather best rendered as "I am struggling *in order* to learn". The notion of 'yelle' conveys that difficulty is inherent to achievement, and vice versa, shifting the focus from the obstacle faced to the process of dealing with it. Here I do not intend to romanticise challenges faced by Acholi people, which risks playing into colonial tropes of the 'natives' as somehow being desensitised to pain and suffering. Rather, I wish to emphasise that notions of normality of crisis are socially shared, and thus seep into the language and are expressed through it. Furthermore, this reinforces the idea that as obstacles are not extraordinary, a 'good existence' does not consist in their absence, but rather in the presence of resources that can be mobilised to overcome them; the 'struggle' is in the strategies adopted to do so.

Crucially, p'Bitek (1986) shows that the idea of 'good existence' relies heavily on the value of *activities*, of both individuals and groups. This idea is closely linked to notions of 'moral personhood' which, while not new, has recently acquired significant relevance in the growing field of psychological anthropology, which is increasingly following the current 'moral turn' of the wider anthropological discipline. Following Myers and Yarris, I understand personhood as "a morally infused mode of being a self-in-the-world" carrying "both embodied and ethical dimensions" (2019:4) which are key for individuals and communities' mental health and healing (Kleinman 1997, 2006) and which if jeopardised can produce deep and existential forms of suffering. Central to a sense of wellbeing is therefore a sense of 'moral personhood',

which can be conceptualised as a deep, embodied sense of what it means to be a 'good and valued person' in one's local social world (Luhrmann 2001; Myers 2016).

Personhood, as a large body of anthropological scholarship has shown, is always intersubjectively negotiated and relationally constituted (Kleinman 2006; Comaroff and Comaroff 2001; Jackson 2002). This recognition finds particular resonance among South Sudanese refugees, and especially among Acholi, where an appreciation of intersubjective and relational dimensions of existence is crucial to everyday decisions around what is good, and even what is real. As shown by p'Bitek's and Porter's works, what it means to be a 'moral person' among Ugandan Acholi is determined by a complex and intricate web of social, cultural, and cosmological notions of good. O'Byrne's (2016) insightful ethnography extends these considerations to South Sudanese Acholi, describing Acholi personhood and modes of being in the world as fundamentally driven by a notion of 'lived pragmatism' – an orientation towards the world that is rooted in actions that can be publicly and relationally acknowledged and validated – and thus continuously oriented towards the achievement and maintenance of 'social harmony'. Echoing p'Bitek's (1986) consideration that good activities contribute to the making of a 'good existence', he notes that in Acholi lifeworlds both personhood, social and cosmological relations, and group membership are established and reinforced by a "conceptualisation of relationality in which familial, lineal, and communal (re)production is tied to pragmatic activities" (2016:113).

In Acholi, as well as among other language groups in Palabek settlement, it is through the act of participation in public life that one becomes a 'good person' ('dano ma ber'). Participation is variously practiced, flaunted, or failed across genders, ages, and language groups, but nevertheless always publicly performed. It is crucial here to note that at the core always remains the social and relational component pointed out by Porter (2016); activities are socially signified, that is, they become meaningful when they can be socially appraised, based on the extent to which they improve (or undermine) 'social harmony' (Porter 2016). It is against this standard that activities and subjectivities are measured; and it is against their outcome that the existential surroundings can be considered 'ber', normal and thriving in the face of crisis, or 'rac' – unbalanced and out of control (p'Bitek 1986).

6. Dealing with insecurity: Acholi vernaculars of affliction and mental disorder

In contexts of political, social, and moral crisis such as those which displacement foregrounds, people rely on local cosmologies and actively engage with them to navigate their way forward (Baines 2010:411). In the recently renewed interest of anthropology for the study of cosmological matters, the latter are not confined to the study of the religious and holy elements within a society, but rather encompass them (Abramson and Holbraad 2012). This perspective rejects an understanding of cosmology as a fixed system, a statically reproduced vision of the world which allows for 'cultural explanation'. Rather, the cosmological can be said to consist of the all-encompassing realm of those cultural logics and principles that are taken for granted and locally considered natural or naturalised (O'Byrne 2016:49), and that play out in everyday life. In the Acholi socio-cultural world, local cosmologies are of such relevance that "the spiritual and physical spheres are not separate but intertwined" (O'Byrne 2015:41), with events in one realm having various and very real consequences on the other. To summarise 'elements 'of Acholi cosmology would risk unduly disconnecting the latter from the "embodied and enacted nature of human life" (O'Byrne 2016:50). Therefore, here it might be more useful to outline some cosmological notion and processes of particular relevance to both Ugandan and South Sudanese Acholi.

A considerable body of literature has shown that Acholi people's experiences of the world are firmly embedded in cosmological dimensions, as often are strategies that people employ to deal with prolonged insecurity (O'Byrne 2014; Baines 2010; Finnström 2008). The Acholi spirit world, the relationship with which is central to ideas of 'good existence' and 'social harmony', is populated by a variety of powerful, extraordinary meta-personal forces (O'Byrne 2016; p'Bitek 1971). In particular, cosmological concepts of cen and jok (plural: jogi) are central to customary Acholi understandings of the world; these are both spiritual forces which heavily impact daily life. Jogi oversee the moral order of a community, holding an ambivalent and unpredictable power, through which they send misfortune when social transgression takes place and until moral order is restored (Baines 2010). Traditionally, jogi are linked to specific clans; but there are free jogi as well, often found in the wilderness – such as mountains, rivers, or 'the bush' ('tim'), an area heavily connotated as linked to moral and spiritual pollution. Interactions with jogi can results in possession or even death (Baines 2005; Victor and Porter 2017). A jok who possesses someone can be exorcised or subjugated; sometimes, this leads to the possessed person becoming a spirit medium ('ajwaka', plural

‘ajwaki’). Forms of possession can be also due to cen, a free jok variously described as ‘ghostly vengeance’ or ‘polluting spirits’ (Allen 2010). Cen is the spirit of a person who either died of a ‘bad’ death, or was treated badly in death (i.e., died by murder or did not receive a decent burial). It is “caught and spread like a contagion” (Porter 2016:135; Meinert and Whyte 2017), and often results in the stigmatisation and social isolation of those affected by it, whose behaviour is often far from the ‘socially normal’ acts that the possibility of ‘good existence’ rests on. Ajwaki are sometimes capable of cleansing or appeasing jok and cen by “socializing and domesticating” them (Victor 2018:92), therefore reinstating social harmony.[20]

These dimensions entertain a close relationship with refugees’ mental health. As described at length by the work of several scholars who have worked in the Ugandan and South Sudanese borderzone, possession by jok and cen are known to cause a wide array of afflictions, including sickness, misfortune, sterility, and madness – all problems which are fundamentally understood as more social (e.g., clan-based) than individual (see e.g., O’Byrne 2014; Victor and Porter 2017; Mogensen 2002; Verginer and Juen 2019; Storer 2020). In these circumstances, “[c]ultivating well-being and preventing misfortune—sicknesses, accidents, madness, premature death, and more—is a matter of spiritual welfare as well as material conditions” (Victor 2018:5). Among Ugandan and South Sudanese Acholi, mental disorders are widely attributed to forms of spiritual possession (see Chapters 7, 8, and 9). In post-conflict northern Uganda, forms of social contagion such as cen indeed seemed to be particularly widespread, and a wide scholarship has investigated their role in causing forms of madness (‘apoya’) during and in the aftermath of the LRA war (e.g., Williams 2019; Yen 2018; Meinert and Whyte 2017; Allen et al. 2022; Victor 2018).

However, things were slightly different across the border. In a study of spiritual dimensions of South Sudanese Acholi lifeworlds in Pajok, O’Byrne (2014) noted that, in contrast to Uganda’s Acholiland, cen was not particularly relevant in his interlocutors’ daily lives. His interlocutors explained that both jok and cen possession were more widespread among Ugandan Acholi communities than South Sudanese Acholi ones, and reportedly felt that “any cen previously connected to the community was left in Uganda when people began returning

[20] However, as pointed out by O’Byrne (2015, 2017), the increasingly prominent role of Christianity in the region has had a significant impact on some of these notions, which are now often linked to the Biblical Satan instead of ‘cen’ (O’Byrne 2016).

to Pajok from 2008" (ibid:30). Anthropological literature has pointed out that a profound sense of social and moral disruption among refugees in Eastern and Central Africa often manifests as a sense of "moral disorder" (Brankamp 2021) and "spiritual insecurity" (Ashforth 2011; Fisher and Leonardi 2021). In particular, literature on Acholi socio-cultural and cosmological worlds has shown that in areas characterised by a high concentration of spiritual entities (e.g., 'the bush', people perceive a higher sense of cosmological, physical, and psychological insecurity (e.g., O'Byrne 2015; Finnström 2008; Porter 2013; Baines 2010). This was particularly evident in Palabek. The perception that cen had not followed people back to South Sudan had contributed to a feeling of safety in Pajok (O'Byrne 2015) until the renewal of violence in the region in 2016 and 2017; however, this also compounded feelings of fear, suspicion, and foreboding experienced by refugees in the settlement. Stories of refugees unintentionally disturbing local free jogi they had encountered in the bush or on nearby hills while looking for firewood or cutting grass were common; here, bodily insecurities related to host communities' hostility met, compounded, and were reinforced by perceptions of cosmological insecurity.

Chapter 3. Methods

1. Introduction

The fieldwork for this thesis was conducted over fourteen months in the refugee settlement of Palabek, located in the northern Ugandan district of Lamwo. After one short scoping trip in October 2018, this time was split into two longer phases between January-June 2019, and between September 2019-March 2020. All the main chapters of this thesis are informed by ethnographic data collected over this period, with the exception of Chapter 6, which builds on extensive critical policy analysis.

The 'basics' of my fieldwork can be covered as follows. Throughout my fieldwork, I lived in Palabek settlement with a family of Acholi-speaking South Sudanese refugees. I carried out over two hundred hours of participant and non-participant observation at Palabek settlement's mental health clinics and clinical home visits, and countless others at psychoeducation sessions, mental health-focused public events and trainings, and community and individual psychosocial interventions carried out across the settlement. I conducted 211 qualitative interviews with refugees, humanitarian workers in Palabek, and a few more with Kampala-based UNHCR officers involved in the mental health component of the Ugandan refugee response. I also used the method of extended case study (Meinert and Whyte 2023) to follow eight refugees diagnosed with a mental disorder in Palabek refugee settlement.

In all these cases, I sought and received verbal consent for each interview conducted, and always made sure that interlocutors (particularly refugees) were aware that I would guarantee their anonymity; that participation in my study was voluntary; and that they could interrupt our exchange at any point. In at least two cases, people refused to be interviewed; in some others, people requested I do not record them, to which I obliged. I take these instances as a positive indication that reassurances around participants' anonymity and voluntary participation was adequately conveyed. I also did my best to communicate the scope of my work, to mitigate the risk of creating hopes and expectations of material benefits that I would not be able to fulfil (see Krause 2017).

However, I understand my methodology to encompass not just the methods that went into the production of this thesis, but also (and perhaps even more importantly) the reflections on

ethics and positionality which helped orient my research practice. All of these require explanation and justification, to which this chapter is dedicated. Ethical considerations are not relegated to one single section or paragraph, but rather fluidly disseminated throughout the whole chapter. This is an intentional choice. Research with refugees and forced migrants must necessarily be conducted with a constant awareness of the power imbalances that characterise it (Marmo 2013; Omata 2020); therefore, ethical considerations underlie every step of my fieldwork, from the selection of the object of study, to engagement with interlocutors and trusted relations, to the analytical and write-up phases. As they cannot be reduced to a 'box-ticking exercise', I return to them throughout this chapter.

2. Getting there

The reasons and circumstances which led me to the study of mental health interventions in Palabek refugee settlement are the product of personal, political, and serendipitous developments which require a brief, and partially autobiographical explanation.

My engagement with the region of northern Uganda began a few years before I conducted the research on which this thesis builds. I first started conducting research in northern Uganda in 2015 and 2016, while I was a Clinical Psychology master's student, returning again in 2017 shortly before the start of my PhD programme. During this time, I contributed to a decades-long research effort, by several researchers based both at the LSE and in Gulu City (at the time, Gulu Town) to investigate the post-conflict social realities of in the region, which was recovering from the bloody civil conflict between the rebel group Lord's Resistance Army (LRA) and the Ugandan government.

During this work, like many other researchers I had investigated the psychological aspects of the stigmatisation often experienced by returned LRA abductees in Gulu district. Interested in the ways in which what Didier Fassin and Richard Rechtman (2009) have called an 'empire of trauma' had extended to northern Uganda, I had interviewed several former LRA combatants about the psychological support that they had received upon returning from captivity. I had also conducted observations at various mental health interventions, which

continued to proliferate in the region, to allegedly support the reintegration process of LRA returnees.[21] During this time, I also began taking Acholi language classes.

These first research experiences in northern Uganda, together with anthropology courses I took during my postgraduate studies, had a significant impact on my future research trajectory. The diffusion of mental health interventions and discourses that I had observed convinced me of the importance of studying the expansion of Western psychological interventions in Uganda, and oriented me towards the ethnographic methods for which clinical psychology rarely allowed. I initially intended to conduct my PhD research in Gulu district; however, having briefly conducted research in this area led me to critically re-evaluate my role as a researcher in an area of northern Uganda where 'research fatigue' was overwhelmingly common among individuals and communities in the post-war period (see e.g., Williams 2019).

Frank conversations with Ugandan friends and colleagues also contributed to ethical considerations that to study post-war mental health interventions in Gulu Town would entail foregrounding the war, at least initially, in my encounters with interlocutors. In so doing, I would risk contributing to the crystallization of a harmful narrative around the Acholi region, which over a decade since the cessation of hostilities kept foregrounding the war as the defining experience of the population (Nibbe 2010; Hopwood 2022). Without denying the value of longitudinal studies which build on longstanding engagements with the region and its people, I realised that by choosing to focus on the post-conflict landscape of LRA-affected districts I risked committing the mistake of "uncommitted ethnographers", who "lack reflexivity and fail to see themselves in the nexus" of their object of study (Van der Geest 2006:314). Simply put, were I to embark in an investigation of the 'empire of trauma' which I aimed to criticise, I would likely be furthering it.

The political events that changed the face of Europe in 2015 and 2016 further shaped my research plans. In 2016 and 2017, I took part in grassroot solidarity movements sparked by the 2015 'long summer of migration', first in Greece and then in Italy. It may sound trite, even saccharine to think of these experiences' part in subsequently shaping my research interests, and the critical humanitarian literature with which I became familiar during my doctorate later led me to think critically of my fleeting participation in these efforts. Yet, the

[21] This work later helped inform the writing of my Master dissertation in Clinical Psychology (unpublished), as well as one co-authored article which critically examined the social implications of the wide implementation of these programmes in northern Uganda (see Torre et al. 2019).

first-hand witnessing of those historical circumstances (which would only become harsher over the following years) played an important role in orienting my research trajectory towards the study of forced migration and the practice of 'engaged anthropology' (Ortner 2019). Taken together, ethical and political considerations convinced me of the need to shift my focus. When in 2017 a huge wave of refugees fleeing violence in South Sudan crossed the border into Uganda, psychosocial humanitarian interventions in the northern region intensified once again, after significantly diminishing in the post-conflict period. I decided to change my initial research plans to study mental health programmes in the newly established refugee settlement of Palabek.

In contrast to other refugee populations (see e.g., Omata 2020), refugees in Palabek were far from 'over-researched' when I first set out to begin my doctoral project, mitigating the risk of contributing to pre-existing research fatigue (see e.g., Clark 2008; Schiltz and Buscher 2018). Specifically, as O'Byrne (2016:67-68) points out, very few accounts have been produced around South Sudanese Acholi communities, which largely constituted the focus of my research in Palabek. This, however, does not eliminate other ethical concerns, and I discuss the ways in which I continuously attempted to mitigate and reflect on ethical risks arising from ethnographic research.

3. Ethnographic methods for this thesis

I describe my methods as ethnographic. By this, I mean that fieldwork for this thesis was grounded in long-term engagement with Palabek refugee settlement and its social, cultural, and political realities, and applied through extended participant observation, narrative analysis, and qualitative interviews.

As described in the introduction to this thesis (Chapter 1), this thesis follows a scalar structure, describing the social lives of mental health interventions in Palabek from the policy level (Chapter 4) to the discursive and therapeutic means through which they are implemented (Chapters 5 to 7), to their interactions with the social and phenomenological experiences of displacement (Chapter 8) and with other therapeutic actors operating locally (Chapter 9). This is a stylistic choice, made to reflect this thesis' intent to show the effect that policies and interventions, have on people's lives and experiences of suffering and morality in displacement, thus departing from the narrative logic of the humanitarian response to

examine how this unfolds in people's lifeworlds. The ethnographic basis of this work, however, means that data collection followed the opposite trend, being gathered at the level of micro-contexts of daily life – what Arthur Kleinman has throughout his scholarship called 'local moral worlds' – while its analysis generated implications for the macro-level of policy landscapes. As Kleinman notes, 'local moral worlds' are the fields where "macro-level socioeconomic and political forces are played out in particular life-settings, and the experience of illness is constituted inter-subjectively as a particular moral reality" (1992:173).

Ethnographic approaches are considered particularly suited for the study of suffering and meaning in crises-affected settings, for being "not primarily about 'therapy' or mental health [but rather allowing for] an analysis of the negotiation of available moral cultures in situations of cultural destabilisation" (Pillen 2000:100). I found this to be true, but I also quickly realised that a study of psychological interventions in the context of the humanitarian response in Palabek needed to be firmly grounded in an understanding of refugees' lifeworlds; only by departing from people's experiences of affliction of both displacement and psychological suffering in Palabek could a clear picture of such fraught moral encounters be grasped. As Jackson notes, domains of knowledge cannot be separated from the world in which people live and act (2005:4). As such, in the context of my research, anthropological methods allowed to analytically apprehend at least three different phenomena: people's process of attribution of sense and significance to displacement conditions;[22] the struggles – socio-economic, moral, and existential – that constituted many people's everyday reality; and the gap that exists between the latter and the institutional ways of addressing forms of psychological suffering.

Though it was immediately evident to me (and I would contend that it would have been to anyone, as it was to so many refugees and humanitarian workers to whom I spoke) that the ways in which these interventions were conceptualised and implemented were insufficient to address forms of psychological suffering in Palabek, to understand the reasons for this disconnect beyond often cited ideas of 'cultural sensitivity' required being drawn into refugees' local moral worlds. Scholars have pointed out that writing about 'the field' risks resulting in exoticisation of the latter (see e.g., Gupta and Ferguson 1997) and I am cautious in depicting my fieldwork experience as a 'descent' into the life of 'Others'. Throughout my

[22] Jackson differentiates between the 'sense of an event' and its significance, where the former pertains to "the irreducibility of its meaning", and the latter to the event's "social and ethical ramifications" (2005:xxvii).

fieldwork I tried my best to avoid thinking of my ethnographic practice as a way to somehow unveil refugees' "culture", but rather as an enactment of participation in embodied social practices and daily activities, for "everyday life [..] or what the phenomenologists call the lifeworld, is above all a social world" (Finnström 2008:26). This meant participating as much as possible to life outside the sites of my mental health-focused participant observation (see section 7 in this chapter), 'sharing of space and time' across the different contexts in which my interlocutors' social lives unfolded (Tjørnhøj-Thomsen and Whyte 2008:94) and adopting 'radical empiricism' as a mode of enquiry (Jackson 1989; see also O'Byrne 2016) to investigate research participants' experiences of psychological and social suffering. Radical empiricism, as a philosophical standpoint, consists in considering the plurality of dimensions that contributed to existential conditions, whether "conjunctive and disjunctive, fixed and fluid, social and personal, theoretical and practical, subjective and objective, mental and physical, real and illusory" (James 1976:22-23 in Jackson 1989:7).

This does not simply constitute an epistemological and methodological choice, but a crucial component of a post-colonial ethical approach to the power asymmetries in which research with refugees is embedded, and which seeks to avoid instances of epistemic injustice and domination (Marmo 2013). The prioritisation of the worldview which emerged from refugees' lifeworlds also means that I seek to focus on the "phenomenological immediacy" (Jenkins 2015:12) of individuals' narratives, whose verbal accounts of their experiences I do not seek to over-interpret, instead understanding them as carrying the "force of literality" (Biehl 2010:76).

This begets the question of how I understand the forms of psychological and social suffering that I observed during my fieldwork and describe in this thesis. Taking seriously a stance of 'radical empiricism' was vital in at least partially mitigating the psychocentric bias of my previous education in clinical psychology, while at the same time avoiding falling into the trap of social constructionism of psychological suffering and mental disorder. My epistemological approach to forms of social and psychological affliction in Palabek is best summarised by a consideration put forward by Veena Das in her study of urban poor in India. Das states: "I saw too much suffering and violence to say that mental illness is all a matter of social construction or that symptoms are only forms of resistance" (2015:104). I agree; the experiential depth through which my interlocutors embodied the structural challenges of life in Palabek would make evoking ideas of social construction of states of affliction a form of epistemic violence in itself. I conceptualise forms of psychological suffering experienced by

my interlocutors as “extraordinary conditions” (Jenkins 2015), best understood as manifestations of “fundamental human processes” (ibid:2) in circumstances of adversity (see Chapter 2).

Throughout the thesis I often refer to my interlocutors’ experiences of suffering as both ‘mental disorder’ and ‘mental illness’. The choice of terms when writing analytically about psychological suffering, as noted by Williams (2019:28), in its essence relates to the epistemological problem of how we think about experiences of affliction. As such, I have attempted to implement a balanced use of both terms for different purposes. Following Good and colleagues (2008), I use the term ‘mental disorder’ as it provides the opportunity to “explore modalities of social life and subjectivities that reflect, ironically, the establishment of political, moral, and epistemic orders through state violence that reproduces disorder” (ibid:8). It is therefore a notion which allows for discussion of forms of suffering as embodied experiences of structural violence, and thus deeply linked to notions of political subjectivity.

On the other hand, where I use the contested biomedical language of ‘mental illness’ and ‘Western’ diagnostic labels, this should be read as a choice made to foreground the central role of psychiatric knowledge and tools in shaping my interlocutors’ experiences of affliction. At the same time, however, I do not wish to suggest that the reality of mental distress of refugees in Palabek can be denied; nor that those conditions cannot, at times, constitute pathological entities (as, often, the disruption they cause to people’s lives means they very much can). The issue lies in the framing of causes – and, crucially, in what therapeutic solutions are identified in so doing. My effort is that of situating and understanding the forms of psychological suffering I observed in the clinical sites of my fieldwork within the wider lifeworlds of refugees in Palabek. In doing so, Jenkins’ notion of “extraordinary conditions” (2015) appeals to me specifically because of its positing a continuum where the role of structural forms of violence is always present – a continuum which is best examined ethnographically, for it unfolds across the social, moral, and temporal realities of people’s lifeworlds. The forms of affliction that so deeply marked the lives of my research participants should not be understood as discrete categories of experience, rigidly marked by pathological boundaries and firmly discernible from those of the local moral worlds in which research participants’ lives unfold. Indeed, their worries, hopes, and anxieties largely overlap with those of most refugees; whether considered pathological or not by biomedical psychiatry, all these forms of affliction can be read as acute manifestations of forms of social suffering that

widely concern refugees in Palabek settlement. The point, I contend, is less about whether states of affliction can be said to be pathological and more about identifying the structural factors underlying "extraordinary conditions", and the ways in which institutions re-produce them by employing psychocentric registers and tools. As Das notes: "The trajectory of the illness cannot be separated from the failure of institutions in [interlocutors'] local world[s]" (2015:105).

4. 'Whose' social worlds?

My fieldwork largely revolved around the Acholi language group,[23] and the social and moral ways in which experiences of suffering are understood, experienced, and acted upon among Acholi people. This was less the result of conscious decisions and more that of natural developments of my research, as well as of structural characteristics of the humanitarian response. As far as the former is concerned, my fieldwork experience in Palabek was a distinctly Acholi one. This happened quite organically; my two research assistants and most of my initial contacts belonged to the Acholi community – mostly originating from Pajok and the wider Eastern Equatoria region.[24] I lived with an Acholi family; I ate Acholi food, familiarised myself with Acholi sayings and mental health vernacular, participated in Acholi celebrations, funerals, and community meetings, listened to Acholi music on the radio in the evenings, learnt Acholi songs to soothe restless children (generally without success, but much to the amusement of anyone around who heard my mistakes and mispronunciation). My efforts in learning the language were also entirely directed at the Acholi dialect.

Most of my interlocutors, and particularly those whom I identified during my observations at the Health Centres, also identified as belonging to the Acholi language group. Partly, this reflected the demographic make-up of Palabek refugee settlement, where the Acholi group

[23] Throughout this thesis, I generally refer to various refugee communities in Palabek as 'language' groups, refraining from ideas of 'ethnicity' and 'tribe' which, while often used by refugee themselves as well as Ugandan humanitarian staff, have been pointed out as unhelpful, misleading, and perpetuating ideas of culture as a fixed, dehistoricised conglomerate removed from social processes of change. In particular, the reification that these concepts allow for has lent them to a wide political weaponization in South Sudan, playing a significant role in fuelling the civil conflict in recent years (see e.g., Hutchinson and Jok 2002). For a comprehensive overview of this and similar debates, see e.g., Eriksen 2010; Allen 1996.

[24] I briefly worked with two additional research assistants and translators, both young refugees respectively belonging to the Nuer and Lotuko group. In both cases, however, the collaboration was limited to the interviewing of a limited number of people of both language groups in the context of the project undertaken under CPAID (see p. 91).

remained the most numerous. However, it was also a result of the general lack of translators from Acholi into the many other South Sudanese languages spoken in the settlement. Most of the humanitarian staff, and the overwhelming majority of those operating at the settlement's Health Centres, originated from northern Uganda and were Acholi too; while this simplified interactions with Acholi refugees, it also meant that the Acholi group were the most likely to seek medical help, and thus more likely to be diagnosed with a mental disorder.[25]

However, focusing on Acholi refugees was also a choice borne out of the necessity of narrowing my methodological focus, particularly as my research began to focus more on individual experiences of suffering and displacement. As I set out to begin my research in Palabek refugee settlement, my plan was to study what at the time I conceptualised as a relatively 'clear-cut' phenomenon – the 'encounter', which I hypothesised would take place within the circumscribed limits of the settlement, between Western trauma-focused narratives of mental health imported by the humanitarian response, and local understandings of mental illness and health. As a colleague told me shortly before I left for fieldwork, "research plans are made to be dismantled", and I soon realised that most premises underlying my initial research project were inaccurate, naïve, or outright faulty. Firstly, the humanitarian mental health landscape in Palabek differed substantially from that which I had previously observed in and around Gulu City; trauma discourses, while present, tended to dominate organisational workshops rather than clinical encounters, and brief interventions were more focused on the issue of depression. Furthermore, I was not expecting to find an established (if small and understaffed) weekly mental health clinic, or to encounter the prescription of psychopharmaceuticals (to which Chapters 6 and 7 are dedicated) as a widespread occurrence in Palabek settlement.

Crucially, there was little about Palabek that could be said to be circumscribed solely to the settlement itself; rather, the reality of the settlement was one were people, goods, and knowledge circulated much quicker and wider than I had expected. During the course of my fieldwork, furthermore, the population of the settlement grew enormously, going from 32,000 refugees in 2018 (OPM and UNHCR 2018) to around 54,000 in early 2020, with the highest number of new arrivals recorded in June 2019 (OPM and UNHCR 2020). New arrivals

[25] Challenges around the communication with humanitarian staff, and particularly health workers, heavily influenced the perception of discrimination often voiced by non-Acholi refugees. This needs to be recognised as at least partially accurate, as Acholi humanitarian workers often displayed discriminatory attitudes towards non-Acholi individuals and groups. This frequently involved the employment of classic colonial tropes which described them as 'aggressive', 'uncooperative', 'unintelligent', and even 'primitive'.

mostly belonged to Lotuko, Langi, and Nuer language groups, partly challenging what O'Byrne and Ogeno (2020) accurately described as a "decidedly Acholi feel" (2020:753) of Palabek settlement. This complicated ideas of what 'local' systems of knowledge could constitute in Palabek, where the increasing variety of ethnic and language groups made widespread experiences of suffering less readable through lenses of 'culture' (already problematic, and reductively suggestive of fixed sets of norms which do not mirror social realities). In conducting research in Palabek settlement, therefore, the 'messiness' of ethnographic fieldwork (Billo and Hiemstra 2013) met the 'messiness' of borderzones.

This posed a specific set of problems, as it would have been entirely inaccurate to think of refugees in Palabek as constituting a homogenous socio-cultural conglomerate. Lisa Malkki describes facing a similar challenge in her seminal research on identity construction among Hutu and Tutsi refugees in a Tanzanian camp (see Malkki 1996). In reflecting on the impermanence of social realities in refugee settings, she asks: "What do we do with fleeting, transitory phenomena that are not produced by any particular cultural grammar?" (Malkki 1997:87).[26] Indeed, how one ethnographically navigates contexts where social reality is produced by a plurality of social and cultural practices pertaining to different groups is still a fair and relevant question (and also arguably why so many ethnographers working in complex cultural environments such as refugee settings often rely on qualitative surveys on top of ethnography – see e.g., Harrell-Bond 1986; Sackett 2023).

Despite the richness of the social worlds that anthropologists can access through ethnographic methods, it must be kept in mind that the latter are "prone to create snapshot, ahistorical impressions, ignoring substantive, longer-term transformations" (Allen 1989:48) as well as past developments that may help denaturalise present circumstances. While retaining the specificity of current social, historical, and political circumstances – both from an East-African as well as a global perspective – the current wave of displacement needs to be historicised keeping in mind the long-standing cross-border mobility described in Chapter 2 needs. In this sense, the current wave of displacement can be more accurately understood less as the "fleeting, transitory phenomen[on] that is not produced by any particular cultural

[26] It is worth noting that Malkki grappled with this dilemma at a time in which the discipline of anthropology struggled to give up on ideas of culture as more or less stable and localised objects of study, as it is evident from the questions at the core of the book where her essay was published (Gupta and Ferguson 1997). Things have changed since, and deconstructionist and poststructuralist debates have casted doubt over the concept of 'culture' as a fixed set of beliefs and structures, focusing instead on intersubjective social processes as the fluid site of construction of human experience (see e.g., Sökefeld 1999; Clifford and Marcus 1986; Jackson 1989).

grammar" described by Malkki (1997:87), and more as situated within a well-known regional and historical trend of cross-border mobility, social exchange, and shifting political equilibria. Thus, understandings of displacement as eliciting unprecedented forms of movement and social configurations are problematic and at least partially inaccurate when applied to northern Uganda, and especially so in the case of Acholi refugees in Palabek settlement.

5. The focus on medication

Several chapters of this thesis (Chapters 6, 7, and 8) explore issues related to the circulation, prescription, and efficacy of psychiatric medications in Palabek refugee settlement. I should note that a focus on psychopharmaceuticals was not part of the research that I had anticipated I would carry out in Palabek; the choice to focus on these therapeutic tools was driven by empirical considerations, which emerged from the field, that require a brief explanation.

5. 1 A new problem?

Initially, I had anticipated that non-pharmacological mental health programmes would constitute the primary (and even sole) focus of my observations. Largely, my expectations were based on the general lack of mention of psychiatric treatment in the Ugandan refugee response in humanitarian policy documents available online at the time. A long stage of desk research on MHPSS interventions in refugee settings worldwide, which I had conducted in preparation to my fieldwork, had emphasised the role of non-pharmacological and vaguely defined psychosocial programmes; the same search, when targeted on the Ugandan refugee response, had mostly returned sparse mentions of brief community interventions, suggesting that the latter were the most prominent form of mental health programmes. As I would find out, the absence of psychopharmaceuticals from international organizations' descriptions of mental health programmes in refugee settings are in stark contrast with a pragmatic reality of interventions in which psychiatric treatment is widely used (Chapter 6).

Furthermore, my assumptions on the limited relevance of psychopharmaceuticals were informed by my previous research experience in northern Uganda between 2015 and 2016, mentioned at the beginning of this chapter, during which I had observed several forms of mental health interventions. Delivered by NGOs as part of post-conflict reconstruction efforts

in both urban and rural contexts, these therapeutic programmes consisted mostly in variations of counselling and brief trauma-focused interventions.

The stand-alone prescription of psychopharmaceuticals, on the other hand, did not emerge as particularly widespread in the region. Rather, at the time where I first conducted research in northern Uganda, psychiatric treatment seemed to be mostly employed in the routine management of acute phases of mental disorders at Gulu Referral Hospital, the renovation of which in 2005 had led to the opening of a mental health unit (Yen 2018). As noted by Yen (2018) and by Meinert and Whyte (2020), the prescription of psychiatric medication in post-conflict northern Uganda had largely taken place in conjunction with forms of trauma-focused therapy – and, furthermore, had mostly been limited to the early years of the post-conflict period, until the Gulu-based Peter C. Alderman Foundation stopped running a PTSD-focused clinic in 2011. Both Yen (2018) and Williams (2019) describe psychiatric outreaches in rural areas carried out by the NGO Transcultural Psychosocial Organisation (TPO), which largely consisted in the refilling of psychiatric prescriptions and in treatment distribution.[27] However, these had also been taking place with some regularity in the early post-conflict phase, and had become sporadic by the time I conducted my research in 2015 and 2016 in Gulu City.

Considered together, therefore, these empirical and literature-driven observations had led to my expectation that psychopharmaceuticals did not retain a particularly significant presence in humanitarian programmes in northern Uganda. As I soon found out after I moved into Palabek settlement, however, things were remarkably different in the context of the emergency response to the influx of South Sudanese. Indeed, the pervasive presence and reach of psychopharmaceuticals in the therapeutic landscape of Palabek refugee settlement became apparent to me even before I began conducting fieldwork in the settlement.

5.2 A revelatory moment

In early January 2019 I had recently arrived in Gulu City, where I spent a couple of weeks preparing to move into Palabek refugee settlement. I settled into the small house I rented throughout my fieldwork and took daily Acholi language courses. However, most of my time was spent trying to identify and contact field officers of various NGOs which I knew had

[27] As described at length by Baron (2002), TPO had also been involved in the prescription of psychopharmaceuticals in the humanitarian response to a previous influx of South Sudanese refugees in the 1990s.

been or were conducting mental health work in Palabek, to introduce myself and ask permission to conduct observations in their activities ahead of time. For the most part, this was a fruitless and frustrating pursuit. While I thought I would be able to rely on the phone numbers I had acquired from my scoping trip in October 2018, I quickly realised that this was not going to be possible. The aid workers' turnover was such that none of the people I had met a few months earlier were working in Palabek anymore; among the few whose number was still active and with whom I was able to speak, some had been moved to a different settlement, while others had changed job altogether.

This was the case of Paul, a Ugandan Acholi-speaking aid worker whom I had briefly met in October 2018 in Palabek, and the only contact with whom I managed to meet in Gulu before I moved into the settlement. At the time of our first encounter, Paul was hired by the international NGO which managed health services in Palabek at the time as a psychiatric nurse – a job about which he was deeply passionate, and to pursue which he had devoted years of expensive training at Butabika National Referral Mental Hospital in Kampala, the sole specialised psychiatric hospital in Uganda. At the time of our first encounter, he had shown genuine interest in my research, and had spoken at length about his role in Palabek and the mental health needs of the South Sudanese refugee population which he had observed during his clinical work in the settlement. When we met again in Gulu, however, things had changed; Paul was no longer working in Palabek and seemed deeply disillusioned about the possibility of working in refugee settlements, to the point that he had decided to reject the NGO's offer of an extension on his contract and to accept instead a less financially remunerative desk job in Gulu.

This had been a difficult decision, he said while we drank tea in the garden of a quiet café in the outskirts of Gulu. He and his wife had recently welcomed their first child, and while this made it challenging for him to be 'on the field' for long periods of time, he had been tempted to keep his job in Palabek given the relatively good salary and the few employment opportunities in Uganda. The main reason Paul had decided to leave, he explained, had to do with the nature and conditions of the job itself. The few resources he and his colleagues could rely on made it impossible for him to do his job properly: "The funds create problems. We are supposed to cover the entire settlement, but we have no vehicles – reaching Zone 5 is a challenge."[28] He worried about the sustainability of this kind of mental health interventions,

[28] For a description of Zone 5, see Chapter 2.

especially in the event of a withdrawal of UNHCR from the management of refugee operations which would likely ulteriorly reduce funding: "I don't know what will happen if there is a takeover", he sighed.[29] In addition to these pragmatic considerations, however, the lack of funding had clinical consequences which made Paul doubt that he could do his job in a way that he could consider fair and ethical: "Because the funding is little, my colleagues will also have no time [with patients]. They are supposed to counsel them, but they just give medication, medication, medication. The patients that come back are few, and this also creates the risk of relapses."

At the time, I noted Paul's words with interest; however, it was only when I began regularly conducting participant observation at Palabek's mental health clinic over the following months (see below) that I realised the extent to which psychopharmaceuticals were central to psychological interventions in the settlement. In hindsight, I came to understand this informal conversation as an early "revelatory moment" (Trigger et al. 2012) of my fieldwork, as it introduced me to an issue that became one of the core pillars of my research. The circulation of psychopharmaceuticals in Palabek seemed to me to embody several crucial aspects of the issues that I was observing in Palabek; from the psychocentric nature of interventions, coherent with ideas of individual self-reliance, to humanitarianism's intersection with global mental health policy and practice, and finally to forms of "therapeutic governance" (Pupavac 2001) in the context of adversity created by an insufficient humanitarian response. The investigation of clinical practices related to psychiatric treatment in Palabek settlement, and refugees' experiences and understandings of it, soon became one of my main lines of inquiry, developing into one of the principal empirical axes that helped orient my research practice.

6. The fieldwork: temporality and sites

In this section, I provide an overview of the timeline of my fieldwork and of the sites within Palabek settlement which were particularly significant for my data collection. I am wary of presenting a curated narrative about my research trajectory as entirely guided by a series of logical choices; the "ethnographer's path", as Meinert notes, can only be retrospectively reconstructed (2009:26). This is not to do a disservice to my own research practice, but rather

[29] An example of the operational consequences and refugees' anxieties generated by a similar event have been described at length by Tania Kaiser in the case of Kiryandongo refugee settlement, Western Uganda, in 1997. See e.g., Kaiser 2002.

an attempt to acknowledge the ‘messy’ reality of ethnographic fieldwork, and of the entangled and unexpected turns it may (and often will) take.

6.1 Scoping trip: October 2018

In October 2018, I travelled to northern Uganda for what can be described as a short scoping trip, during which I conducted three separate visits to Palabek refugee settlement. On two occasions I accompanied researchers Ryan O’Byrne and Charles Ogeno, who were wrapping up the research they had been jointly conducting there at the time. Both of them retained strong links with the Acholi Pajok community – O’Byrne from conducting ethnography in Pajok before displacement, and Ogeno, who for the initial two months was my research assistant and translator, had close relatives among the refugees residing in the settlement (see O’Byrne 2016; O’Byrne and Ogeno 2020).[30] During these first visits I was introduced to community leaders and prominent members of the Pajok community residing in Palabek settlement, including Richard and his wife Prossy, whose home I moved into a few months later.

These introductions proved invaluable and show that the anthropologist’s path is also deeply shaped by those who came before us (certainly as ‘munu’, foreigners/white people in Acholi, but especially as ethnographers). Being able to refer to O’Byrne’s work in the settlement, at least initially, facilitated explanations of my own presence to refugees and NGO workers. I stopped doing so shortly after effectively moving into the settlement, in an effort to establish ‘my own’ networks and relations with interlocutors. A third visit to Palabek settlement was conducted jointly with a Ugandan medical doctor working for the NGO International Rescue Committee.

During this time, I started the lengthy process of applying for ethical clearance with the Office of the Prime Minister (OPM) and UNHCR in Kampala to conduct work in the settlement, which I managed to obtain in time for when I officially began my research in January 2019. As noted by Sampson and Thomas, however, the negotiation of access to the field is a “full time occupation” for the researcher (2003:173), and this proved particularly true in Palabek. Throughout my research, gaining access was not an activity limited to the settlement itself, but involved a series of introductory meetings with refugee leaders and NGO representatives. While eventually successful, these encounters always involved

[30] The two authors discuss their ties to Pajok more at length in their co-produced work (see O’Byrne and Ogeno 2020).

carefully navigating the atmosphere of continuous suspicion, particularly on the part of NGO workers and OPM representatives, from whom I sometimes got the impression that they feared I was in the settlement in a 'evaluative' or investigative capacity. This was likely related to the audit carried out by the UN towards the end of 2018, which had denounced and (albeit superficially) sanctioned the deep-rooted corruption of the Ugandan refugee response (OIOS 2018; see Chapter 2). As I describe later in this chapter, my sense is that my living in the settlement compounded this suspicion.

6.2 The first phase: January 2019 – June 2019

During the first phase of my fieldwork, between January and June 2019, I began to familiarise myself with the humanitarian landscape governing the mental health part of the refugee response in Palabek. I attended workshops, trainings, and meetings taking place in the settlement; most of these, though not all, revolved around mental health. I also conducted interviews with humanitarian workers, who were mostly happy to talk about their work and reflect on its impact. My principal activity consisted in conducting participant observation during various forms of group psychosocial interventions Cognitive-Behavioural Therapy (CBT) interventions (see Chapters 4 and 5), as well as individual interviews and focus groups with current and former participants, who were almost exclusively women, about their experiences and understandings of these programmes and their lives in displacement. In so doing, I mostly focused on one NGO, which delivered CBT in a series of ten thematic sessions, as it appeared to be the most widely present in the settlement, and one of the few organisations which regularly ventured to remote zones of the settlement for their programmes.

I had initially planned to follow one or more groups for the entire course of the therapy programme, but despite the NGO workers (who referred to themselves as 'counsellors') being friendly towards me and willing to let me observe, achieving this kind of continuity proved difficult. Sessions were often cancelled because of weather or transport problems, frequently with no warning, and then postponed several times or skipped altogether. I made sure, however, to observe each of the ten CBT sessions at least once, in different therapeutic groups. This also allowed me to gain access to a wider variety of participants. The sessions took place in public gathering areas, and it was common for neighbours and passers-by to stop and listen to parts of it; although privacy did not seem to be a significant concern in these settings, I was aware some group members might find the presence of a 'munu'

intimidating. I disclosed my worries to the counsellors, who all reassured me people would not mind. It was unclear if people did, however, as the NGO workers only sporadically let me introduce myself to new groups or asked refugees for their consent about me being there.

During this time, I also began conducting participant observation at the settlement mental health clinics and accompanied psychiatric nurses and officers during home visits (which doctors referred to as the 'psychosocial' component of their work) to some of their patients. It was during this period that I met two of my closest interlocutors, whose stories significantly shaped my understanding of affliction in Palabek. These are Justin (Chapter 7) and Simon (Chapter 8). My engagement with the mental health clinic and those treated there, however, significantly intensified during the second phase of my fieldwork, which I conducted after exiting the field for three months.

6.3 The second phase: September 2019-March 2020

At the time of research, mental health clinics took place three times a week in Palabek refugee settlement – respectively, on Mondays and Tuesdays in the two Health Centres II, and on Wednesdays in the bigger Health Centre III. Crowds gathered early in the morning to seek medical care; often people had to walk for several hours to reach one of the Health Centres, and long waits upon arrival were the norm. To find some respite from the heat and noise, both exacerbated by the tarpaulin and iron sheets of the structures, young girls would lie down to rest on the wooden benches of the covered waiting area, while adults would sit resting their heads on their hands. Other children and their caregivers sat, played, and slept outside of the structures on mats they had brought from home. Those who had anticipated a long wait had brought food from home; others bought cheap snacks from the small kiosks set up just outside the Health Centre gates, mostly run by Ugandan citizens who were quick to identify small business opportunities around the settlement. From morning to evening, the waiting area was crowded and hot, the pace slow and lethargic. Cyclically, the screams of a sick child would generate a sudden change in the atmosphere of the room; other children from different wards would inevitably join the cries (hard to know if in pain or in solidarity), and in a matter of seconds the boredom of the waiting crowd was replaced by a sense of alarm, unease, and fear.

I spent many long days at the Health Centres in Palabek settlement, observing both the 'psychoeducation' sessions delivered publicly and the clinical encounters unfolding in the relative privacy of small, scalding rooms inside the facilities. Here, due partly to my

Whiteness and to my background in clinical psychology, of which doctors were aware, my identity proved challenging to navigate. I found myself in a similar position to that described by Meinert in her ethnography of schools in Eastern Uganda, which she describes as the continuous negotiation of "a position that did not define me as the 'expert in power' and at the same time that did not render me too strange, ambiguous, and even 'dangerous'" (2009:38). Doctors usually introduced me to patients (though this was more likely to happen when the latter was a man rather than a woman) and asked for their consent for me and my research assistant to observe. Consent was never denied; however, I am aware that this question was inscribed in an already unbalanced power relationship between refugees and doctors.

By this time, I was deeply familiar with the context of the settlement, and I was much less reliant on NGO workers than I had been in my initial months of fieldwork. Initially, my research activity at the mental health clinic was limited to the observation of the clinical interviews and diagnostic assessments. However, it soon became clear to me that these encounters were akin to what Jackson describes as 'critical events' "where something vital is at play and at risk, when something memorable or momentous is undergone, and where questions of right and wrongful conduct are felt to be matters of life or death" (Jackson 2005:xxiv). I realised that understanding the workings of humanitarian psychiatry was insufficient without in-depth explorations of fundamental aspects of patients' lives and experiences of affliction in displacement. Thus, I began to approach patients after their consultation, and asking if I could visit them at their homes. Other crucial interlocutors I met serendipitously or were pointed out to me by some of my close relations in the settlement, who had become aware that I was interested in talking to people suffering from 'madness' (in Acholi, apoya).

After doing so, I continued going back for regular visits, the frequency dictated by people's wishes, health conditions, and social engagements. These encounters often started with a few long, open-ended interviews revolving around the affliction my interlocutors were experiencing. However, over time the formality of these initial encounters frequently and organically evolved into familiar interactions populated by sharing food and dull moments, jokes, gossip, and discussions about politics and various aspects of life in the settlement. Many of these interactions lasted for several months – from the first encounter until the end of my fieldwork. Over time, I witnessed several of my interlocutors during more or less acute phases of their affliction. Often, I was able to have long conversations and interviews with

their family members, caregivers, and close relations, and to discuss their views and experiences of their loved ones' predicament, as well as the latter's impact on their own lives.

Veena Das' (2015) ethnographic investigations of suffering among the urban poor in India highlight that mental disorders and forms of affliction gain meaning by virtue of being situated within families and relationships; these same factors, Das notes, significantly impact illness' trajectories and treatment outcomes. As Meinert and Whyte's (2017) studies of HIV and trauma in Uganda emphasise, the process of recognising and attributing meaning to sensations and symptoms is primarily a social one, as is people's relationship with treatment for their condition. these discussions proved incredibly helpful to understand the constellations of relational, moral, gendered, and socio-economic dimensions that participated in my interlocutors' experiences of psychological suffering, and which shaped doubts and negotiations (both public and private) around their treatment.

During the second phase of my fieldwork, I travelled a few times to Kampala to conduct interviews with UNHCR and NGO representatives. On two occasions I also presented initial findings and policy recommendations at UNHCR-led organisational meetings. The first, in which I presented reflections on masculinities and displacement (see Chapter 8) took place in the context of the Mental Health and Psychosocial Support (MHPSS) Working Group; it was attended by Ugandan and non-Ugandan NGO workers, and relatively well received, generating a lively discussion. The audience of my second presentation, at the Health and Nutrition Working Group instead mostly comprised several UNHCR and Uganda Ministry of Health representatives. This time the reception was, at best, mixed. Commenting on my recommendation that prescription of psychiatric medication should be accompanied by an increased food ration for refugees to be able to sustain treatment (see Chapter 7), one Ministry of Health official dismissively commented: "Then every refugee will want to be considered mad".

6.4 Research conducted under the Centre for Public Authority in International Development (CPAID)

In October 2019 I also conducted fifty individual semi-structured interviews exploring perceptions of (in)security among refugees in Palabek settlement for the Centre for Public Authority in International Development (CPAID) at the LSE. Of the interviewees, ten were selected among the refugee elected representatives (Refugee Welfare Council, or RWC) and traditional leaders; the remaining participants were randomly selected among different

language groups across the settlement. This study was intended to represent an extension of a similar study conducted by O'Byrne in Pajok (see O'Byrne 2015). While still unpublished, findings from these interviews were essential in furthering my understanding of people's experiences of displacement in Palabek, and helping me reflect on the relationship between experiences of insecurity and psychological affliction. Undertaking this work allowed me to carry out in-depth interviews with non-Acholi refugees, and thus to verify the validity of many of my findings across language groups.

7. Intersubjective construction of ethnographic knowledge

I conducted the vast majority of the visits and interviews described up to this point jointly with Samuel,[31] my main research assistant from March 2019 until the end of my fieldwork. Samuel is an Acholi-speaking refugee in his thirties who resided in Palabek settlement along with his wife and two daughters, and who also over time became close to the individuals and families that we visited most frequently. His tactful presence and practical assistance were invaluable in more ways than one. A practised translator from Acholi, the most widely spoken language in the settlement and that of most of my interlocutors, he had refined this skill over several years of working with English-speaking researchers and humanitarian organizations in South Sudan. In addition, Samuel provided essential support in continuously helping me navigate some of the challenges posed by my identity, as my Whiteness, gender, and social status made lengthy introductions both an ethical imperative and a pragmatic necessity. The power differentials embedded in the relationship between myself and my interlocutors, of which I was acutely aware and did my best to always consider in both my data gathering and analysis processes, required a continuous brokering of my presence in different social contexts, which ranged from clinical to domestic settings, and from public discussions to private conversations. My research interests required thoughtfully framing the reasons behind my questions, which touched upon intimate matters of suffering, hardship, and illness, and which could easily be regarded with suspicion by participants.

The interrelation of my Whiteness with the topic of my inquiries, furthermore, often led people to initially assume that I retained an affiliation with the settlement's Health Centres or

[31] As in other chapters, all the names have been changed.

with some humanitarian organization. Samuel patiently translated long assurances of anonymity and confidentiality, as well as of my independence from the settlement's aid apparatus. Crucially, he was also able to convey that these conversations were not a form of counselling like that often provided by churches and NGOs, which is rendered in Acholi through to the lexicon of 'sharing thoughts' (nwako tam*),* and which also implies forms of advice giving. Rather, we worked out a way of explaining that what I sought was 'nwako tam i kom apoya': sharing thoughts *about* madness, thus at least partly removing expectations of didactical and hierarchical elements from the exchange. His mediation and our combined efforts worked; often, after some time our interlocutors took to calling him or me to give us news, requesting that we pay them a visit, sometimes jokingly reproaching us for letting too much time pass since the previous one.

Experience, as Jackson (2005) notes, is always intersubjectively constituted; and so is the knowledge generated by ethnographic fieldwork. Samuel and I made a habit of discussing our findings together, to the extent that it became unnecessary to ask him permission to record our conversations. Whenever I reached for my phone, he simply gestured invitingly while we continued discussing the stories we had just heard, recent events in the settlement, or the last news from Pajok. We spent many hours under the shade of the trees in his compound, chatting and eating with his wife and kids. Samuel and I developed a close and trusting relationship, which was among the most significative in shaping my fieldwork and which more accurately qualifies his role as that of a co-researcher (see Krause 2017). A few months after I had left Palabek, he asked me to name his newly born child – an honour usually reserved to clan elders. Knowing he and his wife were fervent Christians, I chose the Acholi name 'Rubangatye'. This was the expression with which Samuel liked to conclude difficult conversations, to avoid ending on a discouraging note, to continuously strive for hope in his life in Palabek: "Olo too, Rubanga tye", he would say; At least, God is there.

Throughout my research, I regularly shared my findings, insights, and questions with trusted relations in Palabek settlement. These long, free-flowing, and quasi-daily exchanges constituted an essential chance for what Finnström has called 'participant reflection', a notion which stresses the importance of a balance between intense participation and taking "a few steps back, to be able to reflect upon what we have learnt and experienced, again step forward and participate" (ibid. 2008:19). Trips to Gulu City, where I briefly returned every week or two, and where my Ugandan research and personal networks were mostly based, also provided countless opportunities for participant reflection.

In addition to its heuristic value, I understand the practice of 'participant reflection' as a form of ethical accountability to my interlocutors – which, as Omata (2020) points out, is an ethical imperative in forced migration research. Ethical research conduct with refugees goes beyond the vague and simplistic notion of 'Do No Harm', and instead consists of a continuous commitment to the construction of collaborative and trustful relationships with interlocutors, grounded in post-colonial awareness of power imbalances as embedded in historical and political dynamics of domination (Mackenzie et al. 2007; Tuhiwai-Smith 2012). Within this complex and unequal cadre, "the researcher *is* the dominant party" (Marmo 2013:94, emphasis in original). The risk of perpetuating epistemic injustice is inherent in the multiple inequalities characterising the researcher-interlocutor relationship, aptly summarised by one of Finnström's interlocutors as: "You need to inject poverty to extract information" (Finnström 2015:225).

By regularly discussing my findings with trusted relations in Palabek, I was able to verify whether my impressions and intuitions resonated within the cultural and experiential grammar of my interlocutors but also, more importantly, whether was I focusing on at that time was a good use of my role as a researcher. By this I do not mean to imply that my role is that of giving voice to the 'voiceless', [32] but rather that my aim was that to foster relations in which my interlocutors could exercise control over the knowledge that was constructed about them and their communities. 'Participant reflection' thus allowed me to combine explorations of refugees' 'local moral worlds' (Kleinman et al. 1997) with attempts to mitigate power asymmetries through a dynamic of reciprocity (Mackenzie et al. 2007) and interpersonal exchange (Finnström 2001), and a continuous "commitment to the intersubjective" (O'Byrne 2015:6).

8. "This is what girls do": reflections on positionality in Palabek settlement

Nowhere during my fieldwork did these dynamics play out in more relevant ways than at Richard's home, where I lived during my time in Palabek. It is impossible to overstate the impact that living in the settlement, and the particular relations which I developed in doing so, had on my research trajectory and on the nature of my findings, as well as on my personal

[32] For a critical discussion of the notion of 'voicelessness' in research with refugees, see Fiddian-Qasmiyeh 2016.

experience of conducting fieldwork. While it was not the site where the participant observation most strictly related to the topic of my research took place, in many ways Richard's home represented the richest and most enlightening component of my research – so much so, that it often seemed to me like I was conducting two kinds of fieldwork at once; the first involving participant observations at mental health interventions, the second concerned with family and everyday dynamics of life in displacement. Soon, however, it became clear to me that the experiences that I was observing were not qualitatively different, but rather fed into one another, unveiling the continuum of "extraordinary conditions" where the experiences of psychological affliction which I was observing were situated.

Richard, the head of the household, was a respected Zone Leader in his late forties. University-educated, in Pajok he had been one of the wealthiest men in the area, owned vast amounts of land, and had even established a computer centre where people could type and print documents. Having hosted missionaries and Euro-American volunteers in the past, he and his wife Prossy were no strangers to welcoming people to their home, and had built a guest 'ot' (mudbrick hut) in their small compound in Palabek, into which I would move. They shared their now limited resources with countless of Richard's 'kaka' members – older relatives, siblings, young nephews and nieces who lived nearby; the compound was rarely empty, with relatives, friends, and people coming to seek Richard's help with issues of all kinds constantly flowing in and out. Among them were half a dozen young men, all related to Richard, who often spent most evenings at his home, forming a tight and entertaining group. They usually came to share a meal, and often hung around afterwards, listening to music on their mobile phones, discussing football, sometimes talking about their romantic relationships and bragging about their sexual ones; frequently, they gathered around Richard to ask him for advice. Soon, I began to glimpse in their lives some of the same challenges that I had heard men cite as a source of deep suffering at the mental health clinic.

As it often happens while conducting ethnographic fieldwork, over time I developed close relationships with several members of the family. I frequently spent time with Prossy at home, chatting in or outside the kitchen, helping with small chores, and with the care of her youngest child. Often, we just kept each other company to beat the boredom whenever the rain or the heat were too intense to be outside. Prossy had an exceptional singing voice, a sharp wit, and a marked sense of humour; but whenever the latter failed, the isolation that she felt in Palabek quickly emerged. Her father and brothers were still in South Sudan, while she

had few close relations among the women of Richard's 'kaka'. Luckily, her sister lived in Palabek too; they visited each other often.

Prossy ran her home like clockwork, with the help of Richard's teenage nieces. Although she was barely older than me, she often joked that I was her daughter – which I understood as partly a way of dealing with my ambiguous status as an unmarried, childless woman (at 27 years old, I was relatively young for European standards, but not in Palabek) staying at her house,[33] and partly based on the fact that the chores I was able to perform were those usually delegated to children (I was never physically capable of carrying heavy jerricans of water for long distances, let alone sacks of maize and beans during food distribution). However, both her and Richard seemed pleased that I was keen to help, while participating in housework was a performance of care that was both ethically and methodologically important for me. "Munu maro tic!" (This white person likes to work!), I would announce while sweeping the compound, removing shrivelled beans, or washing pots and pans. Prossy laughed with Richard's sister and nieces: "In layela!" (You troublemaker!) they would reply, in what became a recurrent inside joke. The pleasure of spending time together felt genuine.

Richard also had a habit of referring to me as a 'young girl', but for different reasons. In the evening, particularly at the beginning of my fieldwork when he felt more obliged to entertain me, Richard and I would often sit outside and talk for long, jokingly referring to our lengthy discussions as the daily 'talk shows'. Richard almost invariably dismissed my naïve attempts to ask questions about life in Palabek or Acholi culture and language; instead, he would ask me about life in Europe, from politics and culture to people's habits, attitudes, and beliefs. His questions were specific and often required me to research them overnight, so we could discuss them again the following day.

Our long chats occasionally took his mind away from the boredom and frustration that he experienced in the settlement, and he seemed content to have me around. I could sense, however, that my presence could at times still be an uncomfortable matter, and that my bringing goods from Gulu, which Prossy and I had negotiated as material 'contribution' for me staying with them, bothered him. Often, he would send me to the kitchen to make tea or

[33] I suspect that my moving into Richard and Prossy's home may at the time have elicited rumours among neighbours. In particular, my being childless posed questions. As Baines (2005) put it, barren women are considered socially 'dead' in Acholi; O'Byrne echoes this consideration, noting that among South Sudanese Acholi, "a barren woman is not only a dangerous conceptual category but an undesirable social one" (2016:44), as infertility is often a consequence of moral transgression (kiir), or a sign that one has been bewitched.

bring him food, or to collect red chili peppers for his meal from nearby bushes. “You are a girl”, he would add. “This is what girls do”. I did not mind the chores, but I was aware that some conflictual dynamics were at play. This happened especially when he was particularly frustrated, or when he had visitors come to his home, often to their manifest surprise at a ‘munu’ being put to work. Richard’s explanation was always the same: “She is a girl. She has to learn”.

Our relationship took a decisive turn when, a few months into my fieldwork, I started volunteering detailed accounts of my days (which I had not done up until that point as I felt unsure myself about my project) and asking him for advice on how to proceed. From then on, Richard became deeply involved in my research, and eager to share his experience of displacement and the psychological toll it had taken on him. Witnessing the impact of the obvious shortcomings of the humanitarian response on his community, which he would thoughtfully and patiently explain to me, Richard often felt deeply discouraged: “This is a prison with no walls”, he often ironically said of the settlement. Above all, however, he feared not being able to support and guide his family members, and particularly his nephews, in circumstances that he himself found challenging to navigate. The responsibility he felt towards his family weighed heavily on him, often emerging in conversation, and silently haunting him as soon as he tried to rest.

Richard suggested I started focusing on men in my research, as humanitarian interventions almost exclusively targeted women and children. His suggestion resonated with what I had been observing until that point, and that had become particularly clear in conversations with his nephews. Thus, I followed Richard’s advice and intentionally included a focus on masculinities into my research, and we kept discussing it throughout my time in Palabek. To my surprise, from that point onwards Richard encouraged me to ask him the very questions he had avoided at the beginning of my fieldwork. We developed a close friendship; nevertheless, he never stopped asking me to bring him food and red chili in the evenings.

The vast literature on reflexivity in anthropological fieldwork points out that the ethnographer’s identity – understood here as “an aggregate of ethnic and religious background, language, age, gender, socio-economic and political status” (Marmo 2013:86) informs, shapes, and pervades all aspects of fieldwork (Billo and Hiemstra 2013). As anthropologist Matthew Desmond states: “Everything about you [the researcher] – your race and gender, where and how you were raised, your temperament and disposition – can

influence whom you meet, what is confided to you, what you are shown, and how you interpret what you see." (2016:325). However, I contend that this may prove not just detrimental to the work, but instead generate important insights. My experience was one where different aspects of my identity were often mobilised, by myself and others, in different situations and for different purposes. Yet, the instances in which my identity was particularly 'in the way' (often to my frustration) were also some of the most meaningful and 'revelatory' moments (see Trigger et al. 2012) of my fieldwork, highlighting crucial ethical and intersubjective dilemmas that deeply shaped my experience in Palabek, and inevitably inform the entirety of my work.

One of these was navigating issues related to positionality in Palabek, and was particularly manifest in the trajectory of my relationship with Richard. The development of our rapport saw a complex interplay of power imbalances (of which, as Porter (2016) notes, people tend to be keenly aware) and gendered dynamics. A schematic interpretation of what happened could be rendered as follows. My sense is that, in the context of Palabek settlement, my socio-economic status and education level (both the products of privilege of which I was deeply aware) highlighted profound power imbalances in my relationship with Richard; my gender, meanwhile, significantly exacerbated them. I suspect that Richard, for whom displacement complicated being able to perform for his family the same role of provider which he had held for many years, found these imbalances challenging to navigate.

From the very beginning, Richard mobilised selected aspects of my identity to act on the power dynamic at play. Firstly, through the gentle but firm refusal of the role of 'informant', he set clear boundaries; in his home, I was to be the one who was questioned. Secondly, by requesting that I act 'like a girl' in his home, he actively reversed the dynamic that would usually foreground my Whiteness (and associated social status), by instead choosing to focus primarily on the gendered dimension of my identity – which, by virtue of the rigid patriarchal structure of Acholi social life, subordinated me and to him. I found this often challenging to navigate, and I suspect that it was for both of us.

Ultimately, however, it seems to me that what made our relationship work, and indeed transform from initially unpredictable (for me) into a sincere and engaged friendship, was the explicit introduction of an element of intellectual reciprocity in our dynamic, which positioned Richard as active part in producing knowledge based on 'what really mattered' (see Kleinman 2006) in the moral world which he and the people he cared about inhabited. I

do not mean to suggest that this effaced the deep inequalities that still characterised our relationship and my very presence in Palabek, of which we were both deeply aware; it did, however, turn them something that we could openly address and discuss, as we often did.

I choose to include this long description in this chapter to show that, if one is to take seriously ethical and methodological suggestions to "Bring your whole self into research" (Hordge-Freeman 2018), which indeed ethnographic practice requires, it is necessary to acknowledge that being a researcher in a complex environment will elicit complex relational experiences. I understand the ethical reflection on them as a crucial component of the "commitment to the intersubjective", as well as a necessary acknowledgement of the multi-layered nature of researcher's identity, positionality, and interpersonal relationships during fieldwork.

9. Living in the settlement: negotiating spatiality and positionality in Palabek

The impact of the researcher's identity is evident in the gendered dynamics described above in the context of Richard's home. Another instance in which issues related to my identity revealed poignant aspects of Palabek's social and political landscape relates to my residing in the settlement during my fieldwork. Living in Palabek presented pragmatic and methodological advantages; it allowed me to avoid exiting the settlement at night, which would have been unsustainable and dangerous, given the conditions of the roads. It also allowed me to participate in life in the settlement after dark, playing a crucial role in establishing a difference between my role in Palabek and that of NGOs, the overwhelming majority of which left the settlement before sunset.

For the first few weeks of fieldwork, I rented a car to travel from Gulu; I soon gave it up, partly because it was an unsustainable expense given my limited PhD budget, but largely because I realised driving a car reinforced a perception that I was associated with the humanitarian apparatus, from which I was eager to distance myself as much as possible. This meant that, when not traveling with Samuel on his motorcycle, I used the settlement's boda-bodas to move around the settlement, or simply walked. People initially were amused by this, but quickly seemed to get used to it. Walking around the settlement seemed to help normalise my living in Palabek; a few days after I first reached the settlement by boda-boda, groups of children playing around Richard and Prossy's home stopped calling me 'munu', and instead took to yelling my name when trying to attract my attention – which, to be clear, my

Whiteness never stopped eliciting. My ‘otherness’ remained; but it did, over time, become more familiar.

Similarly to what described by Krause (2017), the symbolic meaning which my identity assumed in Palabek far surpassed my individual characteristics, and instead was shaped by a constellation of material, institutional, and geopolitical dimensions. When introducing myself to people, for example, explaining that I lived in the settlement positioned me as someone who, at least to some extent, understood the enormous challenges of life in Palabek in intimate and embodied ways. Combined with the fact that many of my questions revolved around people’s daily difficulties which humanitarians were perceived to ignore, my spatial collocation, so distinct from that of NGOs, quickly became morally and politically connotated; living in the settlement meant that I was sometimes perceived to be ‘on their (the refugees’) side’. [34] My sense is that my living in the settlement elicited the same impression in some of the NGO staff and UNHCR and OPM representatives with whom I interacted more frequently. In encounters with humanitarians and government officials, I tried to mitigate this risk as much as I could – namely, by foregrounding my interest in mental health, which sounded less politically contentious than aspects related to the shortcomings of the emergency response. This dynamic, however, was often difficult to navigate. Refugees often requested that I mediate for them with NGOs or UNHCR, while in at least one instance, during one of my closest interlocutors’ hospitalisations (Justin – see Chapter 7), doctors chose to communicate medical decisions to me rather than to Justin’s mother, explicitly identifying me as an ‘advocate’ of the family. [35]

By entering a complex political space, dominated by a frequently polarised opposition between refugees and the humanitarian apparatus, my own identity became politicised by others, challenging any ambition to be a perceived ‘neutral party’ while conducting fieldwork in Palabek. This is a complex issue with wide epistemological and ethical ramifications, and perhaps the biggest challenge I encountered while conducting fieldwork. However, this also allowed me to gain a deeper understanding of how power dynamics unfolded in the settlement. My own biases as a researcher interested in issues of power, inequality, and structural dimensions of violence and injustice, further complicate claims of neutrality.

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[34] I did not assume, however, that being perceived as ‘other’ from the humanitarian apparatus meant that interlocutors did not have false expectations around participation in my research, and kept working to mitigate this risk throughout my fieldwork.

[35] Both Justin’s family and I felt uncomfortable with this, which later led to new discussions with the doctors to further clarify my role.

However, as forms of 'activist' and 'engaged' anthropological research have demonstrated, neutrality is not the only condition which leads to rigorous knowledge production (Ortner 2016). Rather, as Ortner notes, "the only difference is that the biases of work that does not define itself as engaged tend to be hidden, while the biases of engaged anthropology are declared up front" (2015, paragraph 2).

Over three decades ago, Nancy Scheper-Hughes called for a morally and ethically grounded anthropology, going as far as to say: "If we cannot begin to think about social institutions and practices in moral or ethical terms, then anthropology strikes me as quite weak and useless" (1992:21). David Turton (2003) argued that the study of forced migration needs to be aimed at the relief and prevention of the suffering documented by the research; similarly, Omata (2020:691) notes that "research in refugee studies is justified when it aims to improve the lives of forcibly displaced people". As such, research with refugees is necessarily politically connotated; and it is perhaps fitting that the challenges that I encountered in my own positionality during fieldwork in some ways reflected this stance.

10. Limitations

The research on which this PhD thesis builds presents a number of limitations. The first one relates to the potential for generalisation of the findings presented – an issue ever-present in ethnographic practice (Hammersley and Atkinson 2007:32) and made more acute by my focus on the Acholi language group in Palabek. My focus on Acholi-speaking refugees, whilst allowing for an in-depth encounter with Acholi lifeworlds, entails that findings that relate to the social and phenomenological dimensions of experience of displacement, mental health, and psychological treatment are probably largely specific to Acholi refugees.

A second important limitation of my fieldwork relates to the issue of language. While I had been learning Acholi since 2015 and at the time of research could confidently conduct basic conversations, the possibility of relying on the English language, as well as on skilled assistants and translators, kept my Acholi from ever achieving a degree of fluency that would have allowed me to fully understand my interlocutors' thoughtful accounts, let alone conduct fieldwork independently. I was always aware of this issue and tried to mitigate it by familiarising myself with the most relevant words and idioms for my research – namely, expressions related to health and illness, mental states, and situations of hardship, which I

was able to recognise and note while conducting interviews. I was also mindful that Ugandan and South Sudanese Acholi dialects differ in small but at times significant ways and was careful to note when it was the case in relation to my work (e.g., the difference between the Ugandan and South Sudanese Acholi words for madness – see Chapter 7). Organisational meetings and interviews with humanitarian workers took place in English, as did a few interviews with refugees (generally male, older, and well-educated) who were fluent in English. However, nuances of people's accounts may have been, quite literally, lost in translation when the exchange took place in Acholi or other languages. In hindsight, I also believe that an at least superficial knowledge of some of other commonly spoken languages in Palabek (e.g., Lotuko, Lango, Luo, Nuer, Dinka, and Arabic, to name but a few) would have been beneficial.

Thirdly, in my research I mostly focused on men's experiences of mental disorder and displacement, despite women and children being over-represented among refugee populations – both in Palabek, as well as globally. Most of my interlocutors and trusted relations were men of different ages, social status, language group, and socio-economic background. While this was justified by the general dearth of scholarly research on refugee men (see e.g., Turner 2018; Affleck et al. 2018), and despite adopting a relational perspective on gendered issue, I am aware of the relative lack of representation of South Sudanese women's experiences in this work.

Finally, some ethical concerns limit the extent of the findings I choose to discuss in this thesis. For example, during my fieldwork I have followed cases and stories which I choose not to describe in depth, despite their rich ethnographic and analytical value, as I am concerned that the unique circumstances involved may make individuals too easily recognisable. Moreover, during fieldwork I heard countless stories of NGO corruption, institutional violence, and human rights abuses in Palabek settlement; based on my familiarity with the context, I consider most of these accounts credible. However, while throughout the thesis I explicitly identify both the corruption and structural violence of the Ugandan emergency as one of the root causes of much of the suffering I observed among refugees, I do not describe in detail many of these stories and incidents. In some cases, the sources explicitly asked me to avoid using their accounts. Where the choice to refrain from doing so is mine, it is motivated by concerns that I may expose sources to institutional retaliation. My considerations are based on my knowledge of Palabek settlement and of the wider Ugandan context, including Uganda's record of human rights violations, quickly rising

in the increasing authoritarian climate of the country. [36] [37] Abuses concerning refugees are widely known to occur in refugee settings across Uganda, but are less documented, largely due to the limited political authority of refugee leadership (see e.g., Ogeno and O'Byrne 2018). Thus, this thesis focuses on the analysis of the social, psychological, and existential consequences that forms of structural violence had (and continues to have) on refugees' lives – rather than on instances in which these became manifest.

[36] This is exemplified by Uganda's recent termination of its agreement with UN Agency for Human Rights (ONHCR), which from August 2023 prevents the Agency from operating in the country (see e.g., Okiror 2023). President Museveni's regime has become bolder in recent years in terms of violation of human rights, as signalled by the passing of the infamous 'anti-LGBTQ bill' (Human Rights Watch 2023) and by the widespread abduction, jailing, and torture of political opponents of the National Resistance Movement (NRM), the country's ruling party since 1986 (Reuters 2021).

[37] I should note that in one instance I also personally experienced intimidation by the Ugandan police while conducting research in Gulu district in late 2015. I believe that my Whiteness protected me and my Ugandan co-researcher from any serious consequence in that case.

Chapter 4. “Think positive, save a life”? Resilience and mental health interventions as political abandonment in a Ugandan refugee settlement[38]

Abstract

This article investigates the entanglements of resilience-based refugee policies and mental health interventions in the context of the humanitarian response in Palabek refugee settlement, northern Uganda. I show that both resilience refugee policies and mental health humanitarian interventions stem from a development-oriented and neoliberal logic, which shifts responsibility on individuals for their wellbeing and socio-economic status, masking the failures and inadequacies of humanitarian assistance to refugees in Uganda. I argue that refugees’ psychological suffering in Palabek is closely linked to the food insecurity that settlement residents regularly experience. However, psychosocial discourses and interventions disregard socio-economic components of refugees’ distress. By individualising social suffering, mental health interventions in Palabek settlement justify and enable the political abandonment of refugees.

1. Introduction

The concept of resilience began to gain traction in the humanitarian field in the 1980s, and in recent years has become a catch-all term to tackle a vast array of issues in crisis response (Ilcan and Rygiel 2015). A notion with an apparently benign ring to it, resilience is defined by UNHCR as “the ability of individuals, households, communities, national institutions and systems to prevent, absorb, and recover from shocks, while continuing to function and adapt in a way that supports long-term prospects for sustainable development, peace in security, and the attainment of human rights” (UNHCR 2017:3).

[38] This article has been published in the journal Civil Wars. See Torre, C. (2023). “Think Positive, Save a life”? Resilience and Mental Health Interventions as Political Abandonment in a Refugee Settlement in Northern Uganda. *Civil Wars*. https://www.tandfonline.com/doi/abs/10.1080/13698249.2023.2209485

In particular, refugee aid has come to be constructed as aimed at 'building resilience' in displaced communities (Hilhorst 2018), giving a new spin to humanitarianism's old adage of 'helping refugees help themselves'. This approach is particularly prominent in Uganda, a country with a long history of hosting and generating refugees, which currently hosts 1.5 million forcibly displaced people. Since 2016 this figure includes just under a million South Sudanese refugees, who reside in the most recently established settlements, concentrated in the north of the country (UNHCR 2022a). In Uganda, recent policy shifts have established notions of resilience and self-reliance as core pillars of refugee management. Resilience discourses strongly emphasise the role of individual responsibility, constructing people as autonomous economic actors who are capable of self-government for their survival and well-being.

Duffield (2015) has argued that resilience-focused policies lay the ground for states' abandonment of citizens. In refugee situations, where scarcity of resources and complex sociocultural and geopolitical circumstances sharpen pre-existing social inequalities, resilience discourses transfer responsibility for refugees' wellbeing upon themselves. In so doing, however, they divert responsibility away from states and non-governmental institutions (Krause and Schmidt 2020). This legitimises withdrawal of support at a time in which funding availability for refugee emergencies is at an historical low, thus substantiating Hilhorst's warning that resilience humanitarianism may turn into a 'politics of abandonment' (2018:10) of refugees.

However, resilience-thinking is not the only trend to have recently emerged in humanitarian thinking and policy. Over the past twenty years, a rise in the attention for the psychological burden of humanitarian crises has resulted in mental health and psychosocial support interventions (MHPSS) to become an ever-present component of emergency response. This phenomenon has gradually and deeply transformed the way in which humanitarian crises are understood and tackled (Pupavac 2001). In both academic and policy discourses, the needs of crisis-affected populations have come to be increasingly understood in psychological terms, with diagnoses of post-traumatic stress disorder, depression and anxiety dominating popular imageries of emergency (Summerfield 1999; Fassin and Rechtman 2009).

In this article, based on long-term ethnographic fieldwork in the refugee settlement of Palabek, northern Uganda, I analyse mental health interventions in the context of the

Ugandan ‘resilience and self-reliance’ humanitarian landscape from a social justice perspective. Scholars have extensively examined both the resilience and the mental health turn in humanitarianism; however, these shifts are rarely discussed as related to one another, and little is known about their discursive and pragmatic intersections. Mental health interventions are generally understood as clinically relevant and politically neutral; their political significance, however, emerges from an analysis of the contexts – both geopolitical and humanitarian – in which they are implemented.

As argued by Fassin (2011), while the various actors and institutions involved in the design and delivery of humanitarian aid will inevitably respond to emergencies according to their competences, their operations are shaped by the same hegemonic discourses. With this consideration in mind, I begin by discussing the resilience and mental health turn in humanitarianism as stemming from the same dominant ideas of neoliberal governmentality. Secondly, I outline the situation of food insecurity in Palabek settlement, and show that here resilience-based humanitarianism enables the structural and systemic abandonment of refugees. Finally, I argue that mental health interventions and policy narratives in Palabek individualise and medicalise refugees’ socio-economic distress, significantly contributing to a wider politics of abandonment of refugees across Uganda.

2. Context and methods

This article is based on material gathered during fourteen months of ethnographic fieldwork, which I conducted in Palabek refugee settlement, northern Uganda. The settlement is the most recently established in the country, and is now home to over 76,000 South Sudanese refugees (Government of Uganda and UNHCR 2022), with the Acholi-speaking refugee population representing the most numerous group. Palabek is located in a remote area of Lamwo District, one of the least developed in Uganda, where up to 75 per cent of people are estimated to live in poverty (World Bank 2018), and which still suffers heavy social and economic consequences of a brutal civil conflict that devasted northern Uganda between 1986 and 2006. Between October 2018 and March 2020, I lived in Palabek settlement with a family of Acholi-speaking South Sudanese refugees. Interested in the encounter between Western understandings of psychological distress and the lived reality of displacement as

experienced by refugees, I followed the work of several NGOs working in the field of mental health in Palabek and offering a range of different interventions.

Living in the settlement, which most humanitarian and government workers would leave before sunset, allowed me to position myself as separate from the refugee management apparatus. This gave me the chance to build relationships and engage in conversations that would not have happened otherwise, and to closely witness how resilience and self-reliance policies are experienced by refugees in their daily life and how they can affect psychological wellbeing. In particular, the findings that inform this article stem from over two hundred hours of participant and non-participant observation which I conducted at group therapy sessions and at the local mental health clinic in Palabek refugee settlement. I was also allowed to analyse the local mental health clinic's records, to better study the processes through which diagnoses were made. Finally, my arguments are informed by an analysis of the narratives around mental health at various policy and organizational meetings taking place in the settlement during my time in Palabek.

Interviews and observational data were analysed through an inductive approach, which began in the field. During data collection, emerging patterns were identified and discussed with informants and trusted interlocutors to confirm them. Subsequent interviews were conducted to further verify the plausibility of the findings. Informal interactions and discussions with trusted interlocutors in Palabek significantly shaped the trajectory of my research. The importance of these exchanges cannot be underestimated, as they are integral to ethnographic work and serve as powerful reminders that any form of knowledge is produced in intersubjective encounters (see e.g., Jackson 1998). Yet, a social justice-informed analysis such as the one that I seek to put forward in this article cannot prescind from an acknowledgement, however uncomfortable, of the profound power imbalances that underline (and indeed enable) ethnographic research practices in severely under-resourced environments such as Palabek refugee settlement. I am acutely aware that my field research was in many ways facilitated by the significant privilege which my position of researcher granted me, especially in gaining access to the field site. Furthermore, my race and social class meant that researcher-informant relationships were always characterised by profound power asymmetries, which I did my best to mitigate by emphasising the voluntary nature of research participation and ensuring complete confidentiality during interviews and conversations. Furthermore, I discussed findings with my research assistants, translators, and

closest relations in the field, keeping in mind that both my whiteness and intellectual positionality inevitably informed what I was observing.

Ethical approval for this study was obtained from the London School of Economics (LSE), Uganda National Council for Science and Technology (UNCST) and Ugandan Office of the Prime Minister (OPM).

3. Resilience, mental health, and the neoliberalisation of the global migration regime

In recent years, the search for durable solutions for refugees and forced migrants has become one of the most pressing issues facing the international community. In 2021, the number of forcibly displaced people worldwide reached the record-high of 89.3 million, including over 27 million refugees (UNHCR 2022a). Protracted refugee situations, where displacement lasts for over five years, are a reality for 80% of refugees and are quickly expanding, particularly across the Global South. Overall, the ever-expanding nature of forced migration poses major obstacles to the 2030 Agenda for Sustainable Development goal to 'leave no one behind' (UNHCR n.d.).

At a time in which the increasing resistance of countries in the Global North to accept refugees and asylum seekers severely restricts possibilities for third-country resettlement (Hansen 2018), resilience became a central notion in refugee policy. In refugee situations, resilience-focused narratives portray resourceful and mutually supportive individuals and communities able to cope with crisis (Cretney 2014), implying that pathways to durable solutions can be found in the countries of arrival of forced migrants. Crucially, since 2016 'resilience and self-reliance' is one of the core pillars of the Comprehensive Refugee Response Framework (CRRF), the latest refugee management strategy adopted internationally. The centrality of resilience in the CRRF signals a major shift in ideas on the nature of crisis and disaster in policy and academic literature, as well as the establishment of what scholars have called resilience or resiliency humanitarianism (see Hilhorst 2018 and Ilcan and Rygiel 2015, respectively) – that is, an approach to aid centred around people's existing capacities to recover.

As noted by Felli, the adoption of the notion of resilience in development discourse is "much less theoretical and much more instrumental" (2016:23). Resilience is hardly an operational term, but rather a descriptive and aspirational one; as such, it needs to be understood in combination with the notion of 'self-reliance', with which resilience is often paired. Self-reliance is described as the ability of individuals and communities to meet essential needs in a sustainable way (UNHCR 2005), ultimately to gain independence from humanitarian assistance. Far from being a new idea in refugee policy, self-reliance has been at the centre of UNHCR entrepreneurship-focused initiatives at least since the 1960s, to the extent that it is often portrayed as "the holy grail of global refugee management" (Betts et al. 2017:13). The concepts of resilience and self-reliance are not to be understood as synonyms, but rather as mutually reinforcing notions. As stated by a UNHCR Executive Committee Report: "Self-reliance can lead to resilience, while resilience is necessary to ensure that progress towards self-reliance is not eroded or reversed in the face of sudden-onset shocks and longer-term trends, such as climate change" (UNHCR 2017a:3; Oliver and Boyle 2019). Under resilience frameworks, self-reliance approaches to refugee management have been reinforced and expanded worldwide.

The introduction of resilience discourses has been described as a gateway for states and other actors to normalise neoliberal governmentality,[39] as the imperative to 'be resilient' shifts responsibility onto individuals who are expected to self-govern, be self-aware and adaptable through crisis (Joseph 2013; Welsh 2014). Recent literature argues that resilience humanitarianism, too, operates as a mode of neoliberal governmentality, by constructing refugees as responsible economic subjects and forced displacement crises as opportunities to 'catalyse economic and social development' in refugee camps (Ilcan and Rygiel 2015). The increasing relevance of resilience-focused approaches in humanitarian policy highlights a shift in the conceptualization of emergency, increasingly understood as in continuity with normalcy rather than disrupting it (Hilhorst 2018). Scholars have argued that similar ways of framing risk, uncertainty, and crisis are central features of neoliberal governmentality (Krause and Schmidt 2020). While the notion of emergency "has been internalized and normalized as integral to the functioning of society" (Duffield 2012:481), crisis has become

[39] Neoliberalism is here explicitly understood not merely as a manifestation of a specific economic agenda that decentralizes the state's governance function, but as a political project of 'government at a distance' that acts directly upon individuals' subjectivities, encouraging free conduct through a logic of 'responsabilisation' of citizens (Dean 2010) and of 'economisation' of individuals' social and political lives (Foucault 2008[1979]).

‘the new normal’, and resilience the necessary technology of the self that individuals and communities must develop to thrive in it (Joseph 2013). Accordingly, the narrative around refugees has largely abandoned their characterisation as passive aid victims, instead constructing them as ‘the *lean*, *agile* and *adaptive* subject that [….] thrives in the fitness landscapes of permanent emergency’ (Duffield 2015:139, emphasis in the original).

The resilience-turn in humanitarianism is not the only significant shift to have recently changed the face of humanitarian aid. Over the past two decades, a growing body of literature has advocated for the integration of mental health interventions into humanitarian responses to war and disasters, arguing that such programmes can promote processes of social healing and post-conflict reconstruction (Tol et al. 2011; WHO 2017). As a result, the field of mental health in humanitarian settings has flourished, coming to constitute a new branch of aid known as mental health and psychosocial support, or MHPSS (Jones and Ventevogel 2021). This is not without reason; refugees and other war-affected populations are widely recognised to be particularly at risk of experiencing mental health problems. Recent estimates from WHO state that over 20% of refugees will experience mild or moderate mental disorders (e.g., depression, anxiety disorders, and post-traumatic stress disorder or PTSD), while about 4% may experience severe disorders, such as schizophrenia, bipolar disorder, and major depression (Charlson et al. 2019).

With the expansion of the MHPSS field, however, humanitarian emergencies have been increasingly understood as mental health crises (Summerfield 1999). The expansion of MHPSS interventions has resulted in the increased psychologization of non-Western populations, in what has been described as a form of ‘therapeutic governance’ of post-disaster subjectivities and societies (Pupavac 2001). Nevertheless, MHPSS interventions are now an integral part of humanitarian response to crisis worldwide. The growth of the MHPSS field, particularly in the Global South, is part of the global expansion of a body of lay and professionalized knowledge about the mind which authors have referred to as ‘psy’ (e.g., Vorhölter 2019) or ‘psy-expertise’ (Klein and Mills 2017). Ranging from psychiatric approaches to psychodynamic ones and self-help culture, psy is conceptualized as a broad complex of discourses, practices, and institutions, productive of a psychological self. Psy narratives and interventions largely uphold a psychocentric worldview (Rimke 2016), shaped by assumptions that individual suffering is an effect of “the individual mind […] rather than a

product and expression of social, political, historical, and economic problems" (Rimke 2020:38).

While scholars have pointed out the historically co-constitutive relationship between development practice and psy-expertise, and highlighted their shared colonial history (e.g., Mahone and Vaughan 2007; Howell 2011), in recent years psychological interventions have been increasingly mobilised in development programmes throughout the Global South. This phenomenon is largely the result of a push for the worldwide expansion of psy-expertise originating from the field of global mental health (GMH), a growing assemblage of academic and policy literature which has recently catalysed attention and funding, and whose approach is now widely embraced by the WHO. Firmly rooted in Western psychiatric nosology and practice, the illness model of mental health promoted by WHO and GMH understands mental disorder as universal, framing psychological distress as an 'illness like any other' (Mills 2018).

Both WHO and GMH have been vocal in calling "to scale up the coverage of services for mental disorders in all countries, but especially in low-income and middle-income countries" (Lancet Global Mental Health Group 2007:87). The enthusiasm that this proposition has catalysed needs to be understood within what Mills (2015) refers to as the 'mental health-poverty nexus' – a dominant discourse establishing a close relationship between mental ill-health and chronic poverty, thus portraying mental illness as an obstacle to national and international development agendas. Consequently, mental health has emerged as one of the new frontiers and 'global priorities' of development policy, explicitly demonstrated by its inclusion in the Sustainable Agenda for Development in 2014. As the GMH field emerges as a recognized actor in humanitarian action (Bäärnhielm et al. 2017), mental health interventions are increasingly framed as essential to enable people to lift themselves out of poverty, particularly in crisis-struck low- and middle-income countries (Mills 2018). Development is thus increasingly understood as "a problem of the mind" (Howell 2011:98) to be approached with psychological solutions. Echoing Tania Li (2007)'s considerations on the reductionism and depoliticization brought about by development interventions, Mills (2022) has noted that a universal approach to mental health constructs psychological suffering as a technical problem, removing the social, political, and economic circumstances by which it is shaped and in which it is embedded.

The worldwide expansion of psy has not gone unchallenged. Medical anthropologists have shown that mental health interventions implemented outside of Euro-American contexts often impose Western understandings of mental health, mental illness, and personhood (Summerfield 2008; Kienzler 2008). These notions, they argue, have questionable cross-cultural applicability, and risk disregarding culturally relevant and available forms of support (Summerfield 1999). Critical scholars have also noted that psy practice understands and classifies social phenomena as individual traits, masking political and economic determinants of psychological distress (Mills and Fernando 2014). Crucially, the individualisation and reductionism characterising psy-expertise configures it as consistent with the dynamics of neoliberal capitalism. Authors inspired by Foucault have described the psy complex as a form of intimate governance, pointing out the distinctive neoliberal logic which underlies the expansion of Western psy-expertise (e.g., Rose 1998; Rimke 2016). Marxist critiques, on the other hand, note that contemporary psychological and psychiatric systems within neoliberal capitalism distinguish between individuals who are able to contribute to the free market and those who are not, upholding the logic of neoliberal societies where personal value is predicated on one's ability to produce and perform (e.g., Tseris 2017).

Both resilience and psy frameworks gained prominence in the context of the current humanitarian response to the global refugee crisis, at a time in which the aid industry is particularly dominated by market-centric, neoliberal imaginaries (Oliver and Boyle 2019). As detailed above, resilience humanitarianism is rooted in a neoliberal approach to refugee camps and settlements. Under this framework, such spaces are constructed as sites of individual and collective improvement. Indeed, here the psy complex has become a technology of development; mental health is increasingly tackled through brief cognitive or 'self-help' interventions in refugee settings (see Torre 2021), often embedded in narratives of self-improvement and entrepreneurship. In this sense, the individual and psychocentric focus of the Western mental health interventions fits neatly within the expansion of development-oriented policies enacted under the framework of resilience humanitarianism.

Crucially, these same neoliberal theoretical structures have also significantly shaped a new understanding of emergency, which is now often framed in policy discourse as "a moment and site of profound opportunity for societies to transform themselves so that they might be governed differently" (Reid 2010:404 in Welsh 2014). Thus, if mental health is the way out of crisis and towards development, crises provide vital opportunities to expand psy discourses

and interventions. As its ‘Building Back Better’ report explicitly states (WHO 2013), the WHO identifies the aftermath of crisis and disaster as the best-suited environment to introduce policies aimed at the expansion of mental health services in low- and middle-income countries (Epping-Jordan et al. 2015).

The growth the psy in Uganda clearly exemplifies this process. Over the past three decades, Uganda has been undergoing extensive neoliberal economic reforms (Wiegratz et al. 2018), becoming a well-known ‘donor darling’ of international development programmes. Meanwhile, the country has recently seen a remarkable expansion of psy discourses and expertise, in large part thanks to the widespread presence of MHPSS interventions (Vorhölter 2019). Northern Uganda, a region which between 1986 and 2006 was devastated by a long and bloody civil war (Allen and Vlassenroot 2010; Meinert and Whyte 2017), has provided particularly fertile ground for the introduction of mental health programmes. Throughout the conflict, northern Uganda became the case study par excellence of war-related trauma, with countless humanitarian organizations flooding the region to heal the ‘invisible wounds’ caused by the conflict. Their work consisted of various forms of trauma therapy, often haphazardly implemented, and scarcely monitored (Torre et al. 2019).

Today, the region is again targeted by a variety of psychological programmes, this time as part of the humanitarian response to the huge refugee influx in Uganda. In what follows, I provide an ethnographically-informed overview of life in Palabek, one of Uganda’s thirty refugee settlements. I focus particularly on the widespread food insecurity that settlement residents regularly experience, and analyse the role that psy discourses and interventions play in this humanitarian landscape.

4. Resilience policies and food insecurity in Palabek refugee settlement

In recent years, Uganda has often been depicted by international media and organisations as a model for refugee integration thanks to its self-reliance and development-oriented approach to displacement, gaining a precious reputation as an example of successful refugee management (see e.g., Clements et al. 2016). Self-reliance policies were introduced in the country through the 1999 Self-Reliance Strategy (SRS), and then maintained under subsequent and policies, including the current CRRF (IRRI 2018). It is therefore unsurprising

that when the resilience-focused Comprehensive Refugee Response Framework (CRRF), the latest international refugee management policy described earlier in this article, was piloted in selected refugee situations around the world, Uganda was one of them. Under current laws, refugees are allocated a plot of land, which they are expected to cultivate to achieve a sustainable source of income, and consequently independence from humanitarian assistance. Refugees across Uganda are also granted the right to work, to move freely within the country, and to access free UNHCR-funded education and health services.

However, the potential of current policies for allowing refugees to achieve independence from humanitarian assistance in Uganda has been grossly overstated, and scholars and activists have often denounced the frequent unavailability of freedoms and rights to refugees across the country (O'Byrne and Ogeno 2020; IRRI 2015). Yet, self-reliance policies in Uganda continue being implemented, and indeed expanded under current resilience-focused frameworks. Titeca (2022) has argued that this is largely due to the relation of mutual dependency that Uganda and the European Union entertain with regards to refugee management; the former dependent on international funding, the latter in need of a refugee policy success story to prove the efficacy of Global South-focused solutions.

In Palabek refugee settlement, where the research informing this article was conducted, refugees' everyday lives are deeply shaped by the shortcomings of self-reliance policies. Due to the extreme scarcity of resources and stagnant economy characterising the area surrounding the settlement, refugees in Palabek cannot easily benefit from participation in the regional economic market. For many, therefore, subsistence farming and small-scale market activities within the settlement constitute the main pathway to the achievement of independence from humanitarian assistance. However, this is often challenging, as the plots allocated to refugees are too small to constitute an actual means of livelihood, and the land mostly too rocky or swampy to grow anything other than small amounts of vegetables. Some refugees rent unused land from Ugandans living close to the settlement; for many of my interlocutors, however, this choice resulted in their labour being exploited without any economic gain for them, as they were often chased away after having merely prepared the soil for plantation. Buying a plot of land for agricultural use, meanwhile, requires an availability of resources simply unthinkable for the overwhelming majority of refugees.

If cultivation does not emerge as a realistic pathway to the achievement of self-reliance, the corruption and structural failures characterizing the Ugandan refugee emergency response (Titeca 2022; O'Byrne 2022), pose additional challenges in this sense. Food rations across Ugandan settlements have never been adequate to meet the needs of the overwhelming majority of refugees (IRRI 2018). In Palabek refugee settlement, most people experience significant and chronic food insecurity, particularly during the dry season when the gaps left by the insufficient humanitarian aid cannot be filled by vegetables grown in the plots. Communities employ a variety of self-protection strategies to face external threats and secure basic needs (Gorur and Carstensen 2016; Paddon Rhoads and Sutton 2020). To avoid going hungry in Palabek, refugees often brew and sell alcohol, cut grass to sell in the market, or perform various forms of *leja-leja*, odd temporary jobs, mostly for Ugandan nationals (see e.g., Wilhelm-Solomon 2016), to try and earn small amounts of money. Often, people will rely on family relationships and neighbours for help; however, as one informant explained, doing so offers only temporary relief:

> "*When food is over, there's nothing we can do, especially in dry season when there's not even greens in the house. We can sometimes borrow from neighbours, but then the next month you have to give them back* [what you took], *and you are left with little food again."*

As displacement often disrupts existing networks (Easton-Calabria and Herson 2020), not everyone is able to rely on existing relations. Furthermore, most people resort to selling a significant share of their limited food supply to purchase essential items like soap, medicines, school supplies for children. When asked about how she and her three young children managed without the maize she had had to sell to afford soap, one widowed refugee woman shrugged: *"We reduce on what we eat. We eat once per day"*. Palabek settlement has the highest malnutrition rates in Uganda, estimated to be as high as twelve percent (IPS 2019).

O'Byrne and Ogeno (2020) have shown that food insecurity in Palabek settlement is one of the main reasons leading many refugees to often travel back to South Sudan. They make the journey to look for employment or farm on their ancestral land, in an attempt to overcome inadequate humanitarian assistance, secure livelihoods, and earn a small income. This is not a choice devoid of risk. Although some areas are intermittently free from violence, South Sudan remains a politically unstable context, where the conflict is still ongoing and ceasefires

are volatile (ICG 2021). Crossing the border often results in deadly outcomes. As an older Acholi-speaking refugee recounted: *"One of my friends left the settlement to go back* [to South Sudan]. *He was a teacher, but there was no work for him here in Uganda. He was killed after only two weeks*".

Yet, resilience policies and narratives emphasise refugees' need to be adaptable to continuous adversity, constituting a discursive tool which enables the continued pseudo-implementation of self-reliance policies. However, rather than allowing for economic independence and self-sufficiency, 'resilience and self-reliance' policies in Palabek mask the failings of the humanitarian institutions responsible for food insecurity in the settlement, which expose people to the risk of violence, and establish cycles of indebtedness and impoverishment that become increasingly hard to break. In doing so, such policies effectively work against refugees' wellbeing. In Palabek settlement, resilience humanitarianism translates into the political abandonment of refugees by legitimising the withdrawal of support despite widespread and continuous food insecurity.

5. Mental health and political abandonment in Palabek

The mental health needs of refugees in Uganda have been described as dire and largely unmet (Adaku et al. 2016; Chiumento et al. 2020). Often, studies point out a direct link between the harsh socio-economic conditions that refugees face in the country, and the negative consequences on their wellbeing (Robinson et al. 2022; Bukuluki et al. 2020). The relationship between socio-economic challenges and poor mental health conditions is well-established in the academic literature (Roberts et al. 2022). In particular, food insecurity emerges as prominent in contributing to poor mental health outcomes, and recent studies have shown the correlation between food insecurity and mental health conditions, such as depression and anxiety (e.g., Jones 2017; Pourmotabbed et al. 2020). The scarcity of food resources implies a lack of economic assets that refugees can build on to effectively achieve self-reliance and envision a future for themselves and their families, generating feelings of deprivation, hopelessness, and shame (Trudell et al. 2021).

In Palabek refugee settlement, psychological suffering is particularly widespread (ANS 2020). Psy interventions within the settlements are delivered in various forms – ranging from

public trainings delivered to refugees or humanitarian workers, to short-term interventions such as Cognitive-Behavioural Therapy (CBT), to the recent inclusion of psychiatric consultations and mental health clinic days in the settlement's Health Centres.
As part of my wider doctoral research, I sought to understand whether the distress that strikingly emerged from my ethnographic findings would be reflected in clinical encounters between refugees and mental health medical staff. In addition to conducting participant observations during clinical interviews, therefore, I analysed the settlement's mental health clinic's records, focusing in particular on the time of the year when specific diagnoses were made. This observational study revealed that, for at least two consecutive years, the percentage of patients diagnosed with moderate or severe depression between early December and late March more than doubled in comparison to those in October and November. The time intervals are noteworthy; while the latter is the peak of rainy season, the period between December and March coincides with the peak of dry season, when food is at its scarcest within the settlement. The sharp increase of depression diagnoses during this time indicates therefore a strong relationship between access to food, general scarcity of socio-economic resources, and psychological distress in Palabek refugee settlement.

The relevance of the relationship between access to food and mental health was confirmed in interviews by mental health staff in Palabek, who also pointed out an opposite season trend in Ugandan citizens' depression rates. Across the region, people usually experience various degrees of food-related hardship between May and July, during the peak of the wet season which precedes the first harvest (Schramm et al. 2016).[40] While also experiencing frequent socio-economic difficulties, Ugandans with access to land can employ a variety of coping strategies to mitigate the hunger gap (Twecan et al. 2022). Refugees, on the other hand, are almost entirely dependent on food aid for all food items, with the exception of what they are able to cultivate on their plots. While regular rains offer some respite as small amounts of vegetables can be grown to complement the insufficient food items they receive, during the dry season avoiding long periods of hunger becomes impossible for many. As explained by a psychiatric nurse working in Palabek, who regularly attended to both South Sudanese and local Ugandan patients and often reflected on the impact of socio-economic factors on his patients' wellbeing:

[40] Northern Uganda is characterised by a unimodal rainfall, with a long rainy season lasting generally from March to November (Atube et al. 2022), and a single growing season, with harvesting occurring in August and September (Epule et al. 2021).

> *"There is a big seasonal difference between mental illness in refugees and in* [Ugandan] *nationals. For the nationals, in dry season they are less stressed, they associate with others more often because all the funerals and celebrations are happening then. They can visit people and get money by selling part of their harvest, while in rainy season there is a lot of work to do and then you see depression rising. But for the refugees it is the opposite. Here during dry season, you will see many people with stress disorder and major depression. It is strongly food-related: the food given is little, and you have to sell some of it to buy things like salt, whereas in rainy season people can plant some things and at least change diet."*

These words lucidly illustrate the impact of the failures of the Ugandan humanitarian response on refugees' psychological wellbeing. As it emerges from an analysis of the mental health clinic's records, as well as from interviews with both refugees and mental health workers, in dry season the failures and shortcomings of the Ugandan humanitarian response become particularly evident. The pseudo-implementation of self-reliance strategies, in the form of inadequate food rations and lack of suitable plots of land, is directly linked to psychological distress in Palabek. While at least six national and international NGOs were implementing various MHPSS programmes in Palabek at the time of research, these interventions were far from able to provide meaningful care and support for refugees, and instead reinforced the conditions contributing to refugees' psychological affliction. In what follows, I present ethnographic examples of two manifestations of the psy in Palabek: the instrumentalization of mental health discourses in public and political contexts, and the inclusion of financial trainings within a short-term community psychosocial intervention.

5.1. The entanglements of resilience policies and psy discourses in Palabek

With mental health higher than ever on the humanitarian and development agenda, in October 2019, the Ugandan Office of the Prime Minister (OPM) and UNHCR, which jointly manage the refugee crisis in the country, organised a formal open celebration in Palabek settlement on the occasion of World Mental Health Day. Staff from all the NGOs providing mental health services in the settlement were invited to attend, alongside refugee representatives, settlement residents, and host community members.

The celebration took place in a wide field in front of a primary school, where several rows of plastic chairs had been placed under a tent. Under the burning dry season sun, NGO representatives delivered presentations of their programmes, followed by appreciative speeches by refugee leaders and statements by UNHCR and camp management officials. The extract of a speech delivered in English by a prominent OPM official is worth pointing out. With the help of a translator, he addressed the refugees:

> *"We are not in an emergency situation here anymore, we are in a development situation. I want to tell you that assistance will be reduced. People here are drinking a lot of alcohol, which is one cause of mental illness; they should stop drinking, and instead be busy. The time for emergency has passed, and you have been supported; you should now create your own jobs here in the settlement."* [41]

Behind him, a huge plastic banner hung between two trees read the slogan: *'Think Positive: Save a Life'*, echoing the 'suicide prevention' theme of that year's World Mental Health Day. Refugees listened in silence; a group of women, sitting on mats far from the open area where the speech was being delivered, looked at the OPM representative and chuckled. My research assistant, sitting beside me on a white plastic chair, listened to his words with a serious look on his face. He then commented: *"But how can we be busy if we do not have land and there are no jobs in the settlement?"*

It is worth noting that the attribution of mental disorders to the consumption of psychoactive substances, and especially of alcohol, was not novel; rather, it was often evoked during psycho-education sessions and humanitarian coordination meetings taking place in the settlement. In interviews and casual conversations NGO workers and refugees often remarked, in a matter-of-fact manner, that poverty and unemployment led people to alcoholism – a causal dynamic well-established in policy and academic literature (see e.g., Marlow et al. 2021), and particularly widespread in the social worlds in which the lives of refugees and Ugandan workers alike were embedded (see e.g., Meinert and Whyte 2017). Yet, in both political and organisational discourse in Palabek, the relationship between states

[41] It is worth noting that the food cuts announced during this speech would come into effect in April 2020, amidst the first wave of the Covid-19 pandemic and sudden national lockdowns on a global scale. The Ugandan lockdown, in particular, involved severe restrictions on movement and was among the longest and strictest in the world. The combination of aid cuts and the lockdown would result in severe consequences for refugees' livelihoods and wellbeing (see e.g., Stein et al. 2022; Bukuluki et al. 2020).

of unemployment and alcoholism was left unaddressed or denied – at times with paradoxical results. For example, in the course of a mental health-focused interagency meeting, OPM officials proposed to tackle the rampant issue of alcoholism among refugees in Palabek by issuing a settlement-wide policy that would outlaw brewing and selling alcohol. A loud hum suddenly filled the room – an unusual occurrence, given that the vertical structure of these meetings generally discouraged disagreement from participants. Immediately, an employee of a livelihood-focused NGO stood up and spoke to the OPM official leading the session:

> *"Making the brewing or drinking of alcohol illegal is not the answer. This is an income generating activity…we need to engage people in other income-generating activities if we want it* [alcohol brewing and consumption] *to stop. I have gone to these people, I have had a focus group discussion to understand the drinking issue. This is a psychosocial issue; people drink to forget, because there is nothing for them to do in the settlement."* [42]

Other NGO workers, several of whom had been working in the settlement for extended periods of time, nodded and murmured in agreement. For a couple of minutes, it seemed many of them had anecdotes from their field activities that confirmed their colleague's argument and were eager to discuss them. The OPM official did not engage with the NGO worker's comment, instead repeating that steps towards the outlawing of alcohol production would be considered. Eventually the buzz dissipated, and the coordination meeting continued uneventfully.

5.2 Financial trainings as mental health interventions: psychiatrizing poverty

A group of around thirty South Sudanese women are gathered under the shade of an iron sheet and UNHCR-marked tarpaulin structure. Despite it being early in the day, the heat underneath the roof is suffocating. It is mid-November, and we are approaching the end of rainy season; the rains have already become heavier and shorter, which many people are worried will mean that this year's dry season will start sooner than usual. Deforestation and climate change have heavily affected the seasonal rainfall patterns in the region, which has become more unreliable over the past few years. The women sit in silence on mats on the

[42] Interagency meeting, Palabek refugee settlement, 27 February 2020.

floor, some playing with the small children they brought along, taking them outside when they get too restless.

The structure where the refugees are gathered serves both as an Anglican church on Sundays and as a community meeting point. Today it is the site of a 'financial literacy' training, delivered by one of the main NGOs working in the MHPSS field. This is standard procedure for this organisation and many similar ones. NGO employees tour each area of the settlement and carry out diagnostic interviews with refugees that have been previously identified by local leaders. Those that fit the psycho-diagnostic criteria for depression or PTSD qualify for taking part in the programme, and are divided in groups of ten or twelve participants. Over the next months, the groups undergo ten sessions of Cognitive and Behavioural Therapy (CBT-T) for trauma. Once the sessions are over, representatives from the groups receive a one-day financial training where they are taught basic trade skills (e.g., keeping books and managing savings). Shortly after, the original groups each receive a sum of money (usually up to 600,000 Ugandan shillings, around 155 US dollars) to start a communal business. Only individuals who have undergone CBT are entitled to partake in the business creation. By requiring refugees to undergo a form of therapy in order to access financial resources, this programme establishes a straightforward relationship between mental health and entrepreneurial economic ability – and by the same logic, between mental illness and poverty (Torre 2021). The trainer explains the refugees: *"You have been through ten CBT sessions; this means you are now doing well, so you have to do something".* Throughout the training, conducted in Acholi and translated in Arabic by one of the women for the non-Acholi speakers present, the linguistic register of mental illness is employed several times as a metaphor for poor entrepreneurial spirit: *"If you go to the market and buy a cup of lacere* [small fish] *for 500 shillings and then sell it again for 500 shillings, people will say you are mad in the head!".*

The atmosphere is tense. Just a couple of days ago, the UNHCR announced that this month refugees will receive sorghum instead of maize, while beans will not be distributed. The causes are unclear – some UNHCR and OPM representatives speak of funding shortages, others blame heavy rains ruining the harvest of beans near Kampala. This is not good news; most refugees wholeheartedly dislike sorghum, claiming it is inedible and often falling ill after eating it. However, not receiving beans is a different issue altogether. It is the first time since the beginning of 2018, when food non-delivery was a serious issue for several months

(see O’Byrne 2022), that refugees have been left to fend for themselves for a major part of their basic dietary needs. Throughout the settlement, people are upset and worried; those who can are travelling back to South Sudan hoping to harvest vegetables to bring back to Palabek. Rumours have quickly spread that this may not be a one-time occurrence, but a permanent change. This is cause for grave concern among refugees; if that were to be the case, how will they survive? *“For one month, people can still manage – greens are still there in the garden. But what about when dry season comes? People are crying that they will die”*, a young man commented when the news spread, shaking his head. *“This is how the Ugandan government is telling us they do not care if refugees starve to death”*.

The NGO worker delivering the training seems to think differently. After explaining selling prices and business growth, the trainer discusses the choice of a good product to market. Beans, he says, would be a strategic choice right now:

> *“Yesterday someone told me that World Food Programme is not going to give beans this month. I said, you are very rich now! Go to the village and bring beans to sell, you will make a lot of money because people here don’t have beans. Like a coffin-seller who won’t be sorry for the person who died but instead happy for the business opportunity, don’t mind about World Food Programme!”* [43]

6. Discussion

Following Kapferer (2015) and Das (1995)’s approaches to event description, I consider the vignettes above as critical ethnographic moments allowing for an illustration and analysis of problematics that emerge during anthropological work. In this sense, the scenarios described above are particularly relevant for the purpose of this article, as they show how mental health narratives are selectively employed in policy and community settings in Palabek refugee settlement. The psy complex emerges in both instances as instrumental in justifying decisions to withdraw aid distribution, while psychocentrism serves as a political tool masking institutional responsibility for refugees’ socio-economic hardship. This, I argue, enables the

[43] Financial training in the context of a CBT-T intervention, 14 November 2019.

state's structural violence towards refugees, as well as their political abandonment (Duffield 2015).

To be clear, I am not suggesting that the abandonment of refugees is achieved simply through the introduction and wide-scale implementation of mental health interventions; indeed, the process through which refugees find themselves abandoned by the Ugandan state and international humanitarian institutions is a complex one, which is attained through a multitude of strategic political choices in the management of the country's humanitarian apparatus, and shaped by the encounter of global interests around the management of forced migration with local development agendas, corruption dynamics, and social and historical realities of mobility. However, in practice, psychological programmes and narratives are often used by state and non-governmental organisations in support of arguments which lead to refugees' abandonment. This is particularly significant in the context of Uganda's refugee politics. As argued by Titeca (2022), Uganda is dependent on refugees' presence to maintain its status of trusted recipient of Western development funds; at the same time, the country's pseudo-implementation of self-reliance policies – in the form of lack of adequate assistance and land provision to refugees –ultimately reveals a lack of political will towards refugees' effective self-reliance and long-term residence in the country.[44]

The combination of these factors results in an assistance landscape fraught with contradictions, where Uganda is able to solidify financial streams while disengaging from refugees' needs and social realities through forms of political abandonment, such as scenarios in which refugees are still granted entry and status into the country, but denied protection and possibilities of self-sufficiency and future-making. One such strategy resides in the shift of responsibility for economic survival in arguably impossible circumstances onto individuals themselves, blurring the ethical lines of institutional obligation and leaving refugees to fend for themselves. As this article shows, mental health and psychosocial interventions in Palabek become intimately shaped by the moral and political economy of aid delivery in the context

[44] Furthermore, it is worth noting that these circumstances further narrow refugees' already extremely limited long-term options (Hansen 2018). This is likely to result (and indeed already has) in an increase in mobility towards South Sudan – both in the forms of permanent 'voluntary returns' and in the temporary, informal, and livelihood-oriented movement described by O'Byrne and Ogeno (2020). As the latter have argued, the security situation of South Sudan is so dire that refugees' return to the country, driven as they are by the scarcity of resources in Uganda, represents a significant failure of refugee protection by UNHCR and Ugandan institutions alike.

where they are introduced; as these programmes and narratives are effectively manipulated to justify institutional failures, corruption incidents, and human rights violations, they should be understood as a political tool contributing to the Ugandan state's abandonment of refugees.

The on-the-ground manifestations of this phenomenon are illustrated by the ethnographic vignettes above. In the first example, a mental health event is selected by OPM officials as the occasion to announce the decrease of already insufficient aid distribution, which refugees are encouraged to navigate through self-entrepreneurship. The joint mobilisation of development and psy discourses, coherently with the logic of the 'mental health-poverty nexus' (Mills 2015), allows government representatives to blame refugees for their socio-economic hardship, and to medicalise the causes leading to the latter. Mental distress, on the other hand, is constructed as caused by discrete individual behaviours, such as alcohol consumption, rather than by the structural barriers to survival and self-reliance brought about by the failings of the Ugandan humanitarian response. The attribution of causality of mental distress emerges here as a crucial and politically connotated process. In the interagency policy meeting described, suggestions that alcohol abuse should be understood as an expression of social suffering were disregarded. While alcohol abuse is a widespread phenomenon in refugee contexts across East Africa (e.g., Chiumento et al. 2020), ignoring its social roots places the responsibility for current socio-economic hardship on individuals, rather than on systemic failures. The medicalisation of social suffering has very real effects. The shifting of responsibility from institutions to refugees themselves constitutes here a significant political, discursive, and operational tool which effectively allows institutions to avoid accountability for the neglect of refugees' protection, and for the violation of their human rights.

As the second scenario shows, this view is pushed even further in therapeutic settings such as those of community psychosocial interventions. With the incorporation of financial trainings within Cognitive-Behavioural Therapy, the causal link between mental health disorders and chronic poverty is reiterated. In addition, in these hierarchical therapeutic spaces, refugees are encouraged to understand the lack of humanitarian assistance as a chance to develop self-entrepreneurship, which the context of the training explicitly identifies as a manifestation of good mental health. The links between the psy complex and resilience narratives emerges here as most relevant, showing that in the context of Palabek settlement self-reliance is constructed as not just an economic, but a psychological condition in which people "do not

look to states to secure their wellbeing because they have been disciplined into believing the necessity to secure it for themselves" (Welsh 2014:21). Crisis and the threat of serious food insecurity are here presented as a chance to thrive, while resilience becomes a skill that must necessarily be developed and mobilised as a technology of 'self-enhancement' (Howell 2015) to navigate adversity and chronic crisis. This depoliticising shift of responsibility allows for impunity in the Ugandan government's political abandonment of refugees to a state of permanent emergency, as individualised psychiatric labels provide institutions with an alternative explanatory model for refugees' failure to achieve a state of self-reliance.

In recent years, concerning reports of a significant increase in suicides in refugee settlements across Uganda have emerged (Bukuluki et al. 2021; Bwesige and Snider 2021). In Palabek settlement alone, suicide attempts more than tripled between 2020 and 2021 (UNHR 2022b) – a period during which Uganda experienced a long and strict lockdown due to the Covid-19 pandemic, and emergency assistance to refugees underwent significant cuts (Stein et al. 2022). In the wake of these reports, UNHCR has called for more mental health interventions to be implemented in Ugandan settlements (UNHCR 2020). However, this article highlights the dangers of approaching refugees' wellbeing from a strictly psychocentric perspective. Well exemplified by the slogan *'Think Positive: Save a Life'* chosen for World Mental Health Day in Palabek, psychocentrism allows to disregard the impact of socio-economic elements on refugees' mental health. While the mind is stripped of its social components and understood solely as what lays "between the ears" (Summerfield 2022:680), change is constructed as only possible through self-improvement, and devoid of systemic and structural determinants. Where space should be created for institutional accountability, the individualisation and medicalisation of socio-economic distress instead invalidate and depoliticize refugees' legitimate claims.

This research shows the ways in which, as argued by Rimke, psychocentrism represents "a form of social injustice, where individual reformation rather than social and economic justice is promoted" (2016:5). While this consideration applies widely, in Palabek refugee settlement an ulterior and crucial paradox warrants attention. In this context, observations, interviews, and clinical records show that inadequate assistance and food insecurity are intimately related to psychosocial suffering. The words of the psychiatric nurse on page 119 clearly highlight the causal link between the inadequacy of the humanitarian response and forms of individual and social suffering among refugees. In Palabek settlement, psy discourses and practices do

not simply intersect with resilience ones to uphold aid cuts; rather, existing MHPSS programmes are set out to address manifestations of psychological suffering largely caused by the failures of the humanitarian response, in which such interventions are embedded. When analysed through a social justice perspective, therefore, the psy complex in Palabek refugee settlement appears to serve not refugees' mental health needs, but rather the humanitarian apparatus itself.

7. Conclusion

Within the Ugandan humanitarian landscape, psy expertise, social injustice, and resilience frameworks are to be understood not just as closely conceptually interrelated, but as mutually reinforcing. In allowing for the expansion of psychocentric understandings of refugees' socio-economic challenges, resilience policies in Palabek dilute the political significance of manifestations of refugees' individual and social suffering, obscuring institutional responsibility of state and non-governmental organisations tasked with the protection of refugees. Furthermore, in Palabek settlement, current psy discourses and interventions are employed in both policy and therapeutic settings as political devices that shift responsibility for individuals' economic and psychological survival unto refugee themselves. In so doing, psychocentric MHPSS programmes facilitate the structural and political abandonment of refugees by constructing the latter's socio-economic distress as a medical entity, rather than an outcome of institutional neglect.

The political instrumentalization of psy knowledge and practices is by no means a new problem; rather, it is a phenomenon with deep colonial roots and pervasive global legacies (see e.g., Fanon 1964; Mahone 2006). Yet, it is an issue particularly worth addressing given the increasing expansion of psy expertise in low-resource settings, due to increasing humanitarian and global mental health presence in the Global South. The potential of mental health assemblages for providing meaningful support is not to be entirely disregarded; for example, Vorhölter (2019) has shown that middle-class Ugandans find significant comfort in forms of psychotherapy which have recently gained popularity in the country's capital. The socio-economic characteristics of the context in which interventions are introduced, however, fundamentally shape their meanings and implications, as well their users' priorities and experiences of suffering. In resilience-centred settings such as Palabek refugee settlement, the

increasing psychologization of humanitarian aid upholds what Mahdiani and Ungar (2021) refer to as ‘the dark side of resilience’; that which hinders structural change and requires refugees to adapt to a life of chronic uncertainty.

Therefore, serious questions need to be raised about the ethics of expanding psychocentric MHPSS interventions in the absence of basic resources without first addressing the latter, as well as the structural injustices which underlie circumstances of systemic oppression. There is a real risk that mental health interventions and resilience policies in extremely resource-poor contexts may tend, not to the protection of refugees, but to that of failing international institutions. As emerging studies show, alternatives to psychocentric mental health interventions do exist, which centre users’ priorities and social realities (Haushofer et al. 2021; Jansen et al. 2015). Further research will need to explore the potential of such programmes (e.g., social, livelihood, and cash-based interventions) to generate therapeutic outcomes. Crucially, in doing so it will need to take seriously the role of political, structural, and material circumstances in shaping both refugees’ psychological distress, as well as the significance and implications of mental health interventions themselves.

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Declaration of Interest

The author declares no competing interest.

Chapter 5. CBT and its discontents: ethnographic notes on the failures of a short mental health intervention in the face of structural issues45

1. Introduction

The past thirty years have seen an unprecedented rise in attention towards the mental health of conflict-affected populations. On paper, of course, this seems like a positive development; with recent WHO estimates indicating that rates of common mental disorders among conflict-affected individuals may be as high as 22.1% (Charlson et al. 2019), the acknowledgement of the heavy psychological toll of experiences of war and displacement can be considered a positive milestone.[46] Psychological distress and mental disorders have been found to be particularly prevalent among refugees and forced migrants (Bäärnhielm et al. 2017), as war, displacement, and other profoundly disruptive crises often exacerbate existing mental disorders and may lead to the development of new ones (Ventevogel 2018; Kirmayer et al. 2011). Furthermore, most refugees worldwide live in protracted displacement situations, where displacement lasts longer than five years, exposing people to extended experiences of insecurity and affliction (Weiss et al. 2017; Brun 2015).

This is certainly the case in Uganda, which currently hosts over 1.5 million refugees (UNHCR n.d.), and where humanitarian agencies recently raised the alarm about a worrying wave of suicides in refugee settlements across the country (Bukuluki et al. 2021; UNHCR 2020). Uganda's refugee crisis peaked in recent years due to the influx of close to a million South Sudanese refugees, who crossed the border in large numbers when conflict resumed in South Sudan in 2016. In this context, the mental health needs of the displaced populations in Uganda have been described as dire and largely unmet (Adaku et al. 2016: Tankink et al. 2023), and mental health interventions are a steady part of the humanitarian response. Brief psychological programmes often include a livelihood making component; while it is easy to assume that the combination of therapy and livelihood creation would make a successful

[45] This chapter is an extended version of an article that has been published on the journal Forced Migration Review. See Torre, C. (2021). Therapy in Uganda: A failed MHPSS approach in the face of structural issues. *Forced Migration Review*, *66*, 43–45. https://www.fmreview.org/sites/fmr/files/FMRdownloads/en/issue66/torre.pdf (Appendix 2)

[46] For a critical perspective on these figures, see Chapter 1.

marriage and be beneficial for refugees' mental health, the impact of these interventions is much less straightforward and deserves to be carefully examined.

2. The landscape of mental health assistance in Palabek settlement

Mental health programmes in Palabek range from psychoeducation sessions targeting wide groups to the prescription of psychiatric medication aimed at the most severe cases. Like in most humanitarian settings where resources are scarce and qualified professionals few, non-pharmacological mental health assistance in Palabek largely consists of brief psychological interventions targeting common mental disorders such as anxiety, depression, and post-traumatic stress disorder (PTSD). Despite the frequent lack of thorough evaluations, the general assumption seems to be that these programmes will have at least some sort of beneficial effect; after all, there is a certain allure to the term *psychosocial*, in its unspecific yet benign connotation (see e.g., Abramowitz 2014). However, interviews with beneficiaries of CBT-T shows that this is not always the case; rather, these interventions can even end up having detrimental effects on refugees' mental health when carried out without carefully considering the context of their implementation.

By far the most common among these is a form of trauma-focused Cognitive Behavioural Therapy (CBT). These interventions have a wide reach in Palabek; with at least six different NGOs involved in its delivery, it is common to spot groups of refugees taking part in a CBT-T session when walking or driving around the settlement. Although the evidence for beneficial effects of CBT have been found to be questionable (Bryant et al. 2022; Bangpan et al. 2019), its popularity is not surprising, as CBT offers important advantages in severely resource-poor contexts like that of Palabek. A form of therapy focused on thoughts, beliefs and emotions, in Palabek settlement CBT consists of ten sessions, usually delivered weekly. The success of community interventions such as CBT is largely due to their cost-effectiveness; their delivery requires few material resources, they take place over a limited period of time and can be administered to large groups by minimally trained humanitarian workers (see e.g., Silove et al. 2017). NGO staff who provides these interventions generally have no specific background in mental health or psychosocial work, and often report having been trained for less than three days.

If its cost-effectiveness were not enough to make CBT particularly appealing to NGOs and donors alike, in Palabek refugee settlement the therapeutic component of the intervention is often accompanied by a livelihood one, focused on self-entrepreneurship. In a setting like Uganda, whose national refugee policy is overwhelmingly dominated by a self-reliance narrative, CBT is therefore a perfect fit, as it allows for the confluence of two powerful discourses: the humanitarian and global mental health moral imperative to alleviate refugees' (psychological) suffering, and the development-oriented mantra of 'helping refugees help themselves', which sees self-entrepreneurship as the best way out of chronic poverty and towards the achievement of independence from emergency assistance for displaced populations.

In Palabek refugee settlement, NGOs offering CBT target primarily women, selecting as beneficiaries those that meet the criteria for common mental disorders after having undergone a diagnostic interview. As NGOs are understaffed, the interview process takes place over a couple of minutes, and focuses almost entirely on past traumas. The groups are then taken through ten sessions of CBT. While humanitarian workers generally describe these sessions as 'participatory', in practice they resemble lectures. During the sessions, refugees are encouraged to narrate the traumatic events they have experienced, and taught self-help techniques, mostly in the form of relaxation and breathing exercises. A large part of each session, however, consists in teaching around how to recognise symptoms of mental disorders following Western psychiatric nosology.

After the sessions have ended, the refugees undertake a one-day long 'financial training', where they are taught the basic skills necessary for running a small business (see also Chapter 4). Sometime after the training, they are given a small sum of money (600,000 Ugandan shillings, about 120 GBP) which they are encouraged to use to start a joint business activity among themselves. Upon discussion, some groups choose to start raising poultry or goats, while others prefer selling sugar, soap, and other everyday items. The succession of the steps – that is, therapy before funds – is non-negotiable, and no one who has not been through CBT-T can request to partake in the livelihood creation part of the intervention. The reason, in the words of a CBT trainer, is that: *"We give them CBT so they can forget the past. […] You cannot give money to someone who is traumatised, because they will just throw it away"*.

NGO workers leading the CBT sessions often proudly mention the excellent turnout of beneficiaries, ascribing this to the efficacy of the treatment. They are adamant that CBT is the main part of the intervention and that the refugees are eager to receive psychological therapy. However, interviews with several women from different cohorts of the programme suggest that this view is not necessarily shared by refugees:

> *"They told us when they first came* [to recruit us] *that they would give us money, and that that could make us forget about the past and change our lives. That is why I went, because my children needed clothes and I have no money at all".*

3. CBT and psychoeducation

The relevance of these voices cannot be overlooked, as they suggest that one of the main reasons for such an impressive turnout is not the allegedly sought after psychological component of the interventions, but instead the livelihood component. This hints at a fundamental and often overlooked issue in the delivery of psychological interventions in contexts characterised by extreme poverty; while CBT, an intervention developed in Western contexts and as such firmly rooted in Euro-American notions of personhood, suffering and healing, places the cause of the suffering inside the individual, beneficiaries will often view their distress as a consequence of socio-economic hardship, and will seek a solution to it not so much in the form of self-help techniques, but rather in an actual change of their living circumstances (Roberts et al. 2022; see also Chapter 10). This clashed with biomedical and psychocentric understandings of depression, as it emerged during the psychoeducation sessions which were delivered at the start of CBT cycles, and often reiterated during subsequent meetings. Below are excerpts from one such speech, delivered in Acholi in early 2020 during a CBT session. The counsellor warmly greeted the women sitting in front of him, then began:

> *"I am now going to tell you about the sicknesses that can spoil people's head* (two ma balo wii dano). *First, there is epilepsy; many people in this settlement suffer with this disease. Secondly, there is madness* (apoya). *Do we know that being mad is a disease? When you see someone doing something they are not supposed to do, that is a disease. Someone who is mad, what do they do? They move aimlessly* (lak ataa ataa)*, spoil*

> *people's property, eat very rapidly. A mad person will walk around naked sometimes; he will talk to himself."*

The women chuckled; many nodded in agreement – the NGO worker's description resonated with what they knew. Their response changed when the counsellor carried on: *"And another sickness, having a lot of thoughts, is a disease. Can anyone tell us the symptoms of overthinking?*". This time, the crowd was silent. He continued. The symptoms of 'overthinking' he described almost exactly overlapped with the criteria for diagnoses of depression, as listed in the International Classification of Disorders (ICD), on which the mhGAP guidelines are based:

> *"The person will have heart pain; how many people here have had that? If you have that, you have that sickness. If you have a lot of thought, you will forget what people tell you. Sometimes a person who has a lot of thought is very rude, and will quarrel over small things. When people are laughing or dancing, the person will just sit like this* [the counsellor stood with an exaggerated frown on his face, his arms crossed]. *When there's a community meeting, he will not go and will remain sitting at home; this person does not want to stay with people. They are always very sad* ('cwinye cwe ma tek')*, you will find them crying alone; they will behave like they are sick* ('bed calo kome lit') *even though they are not. They will have no appetite, no energy, not even for washing saucepans. They will give up on themselves, not even want to bathe, and will begin losing hope. So if that person has been with that for quite a long time, sometimes they will be hearing something that is not there, and sometimes they will want to kill themselves".*

It is relevant to note that there is no direct Acholi translation for the term 'depression'. Indeed, as noted in a recent comprehensive report on the mental health of South Sudanese refugees (see Tankink et al. 2023), this is the case for the languages spoken by most South Sudanese refugee groups residing in Uganda. For lack of a better term, mental health staff will use the common idiom of 'overthinking' ('bedo ki tam ma dwong'). In Acholi, this concept can be rendered with a variety of expressions. Two of the most common are 'two par', literally 'the sickness of thinking', and 'bedo ki tam ma dwong', literally 'having too much thinking'. Few studies exist that have examined idioms of 'thinking too much', common across the Global South; however, those that do agree in pointing out that notions do

not always overlap with the Western psychiatric concept of depression and are rather highly specific to cultural contexts and local socio-moral worlds (Backe et al. 2021; Kaiser et al. 2015). This is also the case among South Sudanese Acholi. While people in Palabek describe overthinking in ways which evoke some of the ICD symptoms of depression, such as feelings of overwhelming sadness, insomnia, loss of appetite, and manifestations of social isolation, many descriptions I was given included signs that fall outside the categorisations of the ICD or the DSM, such as being quiet around people, experiencing severe 'heart pain' ('cwiny remo'), or feeling like one's head is stuck ('wic omoko') (Chapter 8).

Crucially, while depression is unequivocally intended by the mental health staff as a pathological condition in need of medical treatment, refugees in Palabek have a vastly different understanding of what it means to 'overthink', and especially of what causes it. The silence of the crowd in the vignette described above, in response to the counsellor's statement that 'overthinking' is a disease, is telling in this sense. *"Par ki apoya pat"*, I was often told: 'overthinking' is different than being mad. Refugees are adamant in locating the roots of 'overthinking', and of the suffering it causes, in the socio-economic hardship they experience in displacement. In the words of an Acholi-speaking woman in Palabek: *"Poverty causes overthinking, or when your child is sick and the money for the medication is not there".* An elder Acholi refugee further explained:

> *"People overthink when they lose their property, like refugees here. Here in the settlement, you will find that everyone is overthinking: they are thinking, the land we are on now is not good for cultivation, and if you don't have food in the house you will think of what you had before, because they* [UNHCR and NGOs] *are not giving enough food.* […] *That is different than an illness."*

As it emerges from these accounts, 'overthinking' is understood by Acholi refugees as a reaction to living in hard conditions; crucially, it is understood as a normal – perhaps even appropriate – response to life circumstances such as those of Palabek settlement, where chronic poverty and food insecurity, in addition to insufficient humanitarian assistance, contribute to shaping widespread social suffering. When asked about her thoughts on the psychoeducation component of CBT, one young woman scoffed: *"I don't have a mental health problem, I have a financial problem!"* Yet, in encounters with mental health interventions, these forms of affliction are turned into individualised medical entities.

Elsewhere (Torre 2020, Appendix 2), I have also argued that one of the main reasons why refugees report wanting to take part in CBT interventions is that, at the beginning of the sessions, they are asked to rate their mood on a scale from 1 to 10 and explain why. This 'mood tracking exercise' is supposed to document individual outcomes from the therapy, but does not have any particular clinical utility; the responses are recorded and used in NGO reports, supposedly to justify requests for additional funding or demonstrate the success of interventions.[47] However, for refugees this represents a rare opportunity to voice at least some of the countless challenges they face in Palabek (Chapter 2), in the hope that this may result in forms of change. Medicalising and individualising discourses hinder refugees' efforts to foreground institutional responsibility and advocate for structural change.

4. CBT's failure: the clash with structural challenges

The assumption underlying CBT-T interventions delivered in Palabek refugee settlement is that after undergoing therapy, the women will be healed from their psychological distress and ready to become independent and successful economic actors. This was unfortunately not the case for most of the women interviewed during the course of this study, who reported no improvement in their wellbeing. In particular, nine former beneficiaries from three different CBT groups, interviewed several times over the course of six months, reported that none of their groups had been able to successfully open and run a business activity in Palabek settlement. Importantly, all of the women interviewed, and the majority of those making up the rest of their groups, had at least some level of experience in trading and running businesses, which they had acquired in South Sudan before fleeing to Uganda. The failure of the intervention should not therefore be attributed to the beneficiaries' scarce knowledge. To understand why the programme not only failed but had detrimental effects (as discussed below), it is necessary to look at the wider context of Palabek settlement, taking into account the structural challenges that the refugees face in this setting, when trying to establish sustainable forms of livelihood.

[47] Due to the structure of the intervention, this strategy is likely successful; by the last CBT-T session, the women tended to rate their mood much higher, explaining that they felt hopeful that they were close to accessing the livelihood phase of the intervention. In this way, however, the NGO was able to demonstrate an increasing trend in users' mood and to discursively present it as a positive outcome of the cognitive component of the intervention.

Located in the rural Lamwo district, one of the poorest in Uganda, the settlement of Palabek is, in the words of an astonished UN worker who visited the settlement for the first time in early 2020, *"by far the worst one in terms of refugee livelihood in the whole of Uganda"* (UN representative, personal communication, March 2020). The plots that Uganda assigns refugees for cultivation purposes are too small to allow for anything more than low-scale and subsistence farming, and the rocky nature of the land in the area frequently prevents even that (Chapter 2). Kitgum Town, the nearest economic centre in a region still struggling with the heavy and long-lasting socio-economic impact of a recent and bloody civil war, is 40km away and expensive to reach; the roads are often unviable, and a two-way bus ticket from Palabek can cost up to 50,000 Ugandan shillings (around 10 GBP). In this sense, refugees living in the settlement are significantly cut off from the lively economic market that characterises other areas of the country. Even after undergoing the huge expense of travelling to Kitgum and purchasing merchandise, however, the women were faced with the exceptionally slow-paced reality of economic life in Palabek settlement. In the words of one of the women that was interviewed: *"I went to Kitgum and bought sugar and 'lacere'* [small fish] *to sell. But there was no one to buy it, the profit was too small. We tried to sell, but people have no money here"*.

Even the groups that were able to sell all the produce they invested in found that the profit was too small, and especially too slow to justify pursuing the business pathway further. Most importantly, however, they had more pressing needs to attend to: the extremely underfunded nature of the current refugee emergency in Uganda means that food and basic needs are never adequately met. For the former CBT-T users there was simply no time to wait for the slow and uncertain growth of an even more uncertain capital. As one of the women commented:

> *"After selling the beans we bought we saved the money and did not buy anything more. Some people went and collected their money. Life here is very hard; when the money is not there you cannot buy food at the market, you cannot buy clothes for the children".*

Another explained the challenges she encountered in her small baking business:

> *"At least in South Sudan we were cultivating, we had land to put food in the house, and we had a business on top of that. We would eat the food we cultivated instead of using the money for the business to eat. But here we cannot cultivate; the land is not good. I have to buy flour to make bread, it will cost 6,000 shillings and I will only make a profit of 500 from it. If I have no food, I have to eat one piece of bread which I would sell for 1,000 shillings; and that is already a loss".*

A third woman agreed with a sigh: *"Here, if you are not careful, you will eat your capital!".*

As for their wellbeing, all the women interviewed reported no improvement in their psychological distress, while some even added they felt even more hopeless than before undergoing CBT.

> "*They told us they would help us forget, but they gave us even more problems. You will try to forget, but then you remember you are a refugee and have no land […] The money they gave us was too little, and now I keep thinking that I cannot do anything".*

Another bluntly stated:

> *"The programme made my life worse. I took the money and bought food and clothes for my children, but I could only buy for some of them; the others have been angry at me since. This* [intervention] *brought separation in my family".*

In several cases, the NGO workers failed to come back to the groups with the funding promised to them after the end of a cognitive-behavioural therapy; whether that money had been lost to small-scale corruption or to the organisation's underfunding was hard to say, but this significantly exacerbated already widespread feelings of hopelessness and political abandonment (Chapter 4). One young woman, commenting on one mental health NGO's failure to provide the money, said: *"They said we could change our lives, that they would come back and help us with money or goats, but they didn't come back. They are just bringing us unhappiness by lying to us".* Another echoed: *"They came and listened to our problems. They promised to help us, but so far they have not given us any help … They treat us like fools".*

5. CBT: a platform for global mental health

Global mental health thinking has only recently begun extending its influence into humanitarian emergencies, and yet its discursive and pragmatic influence in Palabek settlement is already easy to spot. Around the settlement, metal signs display the popular global mental health slogan 'There Is No Health Without Mental Health' and invite refugees to look for psychiatric support at the Health Centres (see Chapters 6 and 7). The same catchphrase appears on t-shirts worn by humanitarian workers. Even the football uniforms distributed to young refugees participating in team sports, which the funding NGO describes as 'psychosocial activities', display one or more global mental health mottos, translated in Acholi.

Global mental health's haunting presence in Palabek, however, is evident in non-pharmacological interventions, too, where it converges with local historical legacies of 'trauma discourses' widespread in northern Uganda (Chapter 1), as well as with current self-reliance agendas which dominate Uganda's approach to refugee management (Chapter 4). In the provision of the form of CBT described in this chapter, the livelihood component which has been embedded in therapy delivered to refugees indicates that CBT-T is constructed as a development tool; refugees, meanwhile, are encouraged to develop entrepreneurship in order to achieve self-reliance.

However, CBT offers a platform to global mental health components as well, through the wide space given to psychoeducation sessions. Here, the intersections between the individualising perspective of development interventions and those of Western psychopathological frameworks clearly emerges. The fact that the (minimal) training of counsellors is entirely based on the WHO Mental Health Global Action Programme (mhGAP) (WHO 2008) is particularly revealing. The mhGAP heavily relies on assumptions of the universalism of mental disorder, and strongly focuses on symptomatic presentation of distress, which is promptly categorised in psychological terms. As public health UNHCR officer explained:

> *"Every worker was trained on how to screen and recognise symptoms and be able to manage them, using existing resources to identify and manage cases. Many refugees*

don't come with mental health issues, they come saying 'I don't eat, I don't sleep', it's up to the health worker to recognise this and this is part of the mhGap training."

Through the provision of psychoeducation, refugees are encouraged to understand their own experiences of distress in individualised and medical ways, which can be dealt with through self-help techniques or through consultations with mental health workers at the settlement Health Centres which, as I show over the next chapters, often result in the prescription of psychopharmacological treatment.

Trauma-focused interventions are not a product of global mental health; as shown in Chapter 1, they have been a longstanding component of humanitarian psychiatry at least since the 1980s (Ibrahim 2021), and have often been argued to individualise and medicalise forms of affliction related to socio-economic hardship (e.g., Summerfield 2004; Kienzler 2008; Bracken et al. 1995). By facilitating the circulation of psychiatric and symptom-focused discourses through training counsellors (and refugees) on narrowly psychopathological models of distress, however, the expansion of global mental health epistemology in humanitarian practice can be argued to magnify existing individualising, pathologising, and ultimately depoliticising tendencies in humanitarian psychiatry.

6. Rethinking refugee mental health

The voices and experiences of the CBT-T users that have been highlighted throughout this chapter highlight the urgent need to critically rethink the design and implementation of brief psychological interventions in extremely resource-poor settings like that of Palabek refugee settlement. In particular, a few key features of mental health interventions based on self-help techniques need to be recognised as deeply problematic. Firstly, by establishing a straightforward connection between mental health and the achievement of economic independence, they medicalise conditions of poverty and refugees' failure to achieve self-reliance. Furthermore, by focusing solely on individual responsibility, both through teaching self-help psychological techniques and through their emphasis on self-entrepreneurship, they fundamentally ignore the structural and wider issues faced by people living in protracted displacement in Palabek.

The amount of money that the former CBT-T beneficiaries in Palabek claimed was too small to meaningfully affect their lives, is indeed to be considered insufficient when the surrounding context is adequately understood. That is a context in which their basic needs were not adequately met, and where the capital they were encouraged to grow had to firstly be used to fill the lack of humanitarian assistance they should have received from the start. If anything, the realisation of how insufficient the sum they were given was led to an increased sense of frustration and hopelessness because it heightened their sense of precariousness. Not only was the money inadequate for their present needs; it made effectively planning for the future a less realistic possibility. Mental health assistance to refugees needs, therefore, to be fundamentally rethought through a temporal and social justice lens, one which focuses on the feasibility of the future and takes into account wider and structural barriers to its attainability.

Chapter 6. A critical investigation of the psychopharmaceutical nexus of Ugandan refugee settlements

1. Introduction

Following a global trend, mental health interventions now constitute a core component of humanitarian operations in refugee settlements across Uganda. Interventions have become deeply entrenched with wider resilience and self-reliance agendas for refugees, whose poor mental health is framed by the government as posing the risk of "making them unproductive members of their communities" (Government of Uganda and UNHCR 2023:8). The heavy reliance of the Ugandan refugee response on psychiatric medications mirrors a global trend; over the past decade, the prescription of psychopharmaceuticals in humanitarian settings across the Global South has become an increasingly widespread practice (Jones and Ventevogel 2021; Ostuzzi et al. 2017). The relevance of psychopharmacological interventions in Palabek refugee settlement struck me as in need of critical analysis, particularly as the continued roll-out of these types of interventions do not seem to be based on clinical evidence of their effectiveness. As noted by Silove and colleagues (2017), there is a dearth of evidence on the efficacy of pharmacotherapies in refugee settings; decades of critical research point out the risks of medicalising non-pathological forms of distress, as well as manifestations of suffering closely related to social determinants of health such as lack of basic needs, poverty, unemployment, discrimination, social isolation, and marginalisation (Ingleby 2014). So, how did we get here? How and why have psychopharmaceutical acquired, and continue to hold, such a central role in emergency responses? What are the concomitant factors that led to pharmacological solutions being increasingly channelled in humanitarian settings? And why has the Ugandan refugee response been particularly targeted by these interventions?

One way to answer these questions is to understand the increased psychopharmaceuticalization of refugee responses as inevitably linked to the growth in humanitarian psychiatry interventions over the past twenty years. Yet, this explanation alone is insufficient to explain the disproportionate psychopharmaceuticalization of humanitarian efforts, which I observed during my fieldwork in Palabek refugee settlement. Rather, the

study of the psychopharmaceuticalization of the Ugandan emergency response requires a consideration of the interconnection of intersecting and multiscalar factors. Petryna and colleagues (2006) argue that 'on-the-ground' manifestations of the globalization of pharmaceuticals are to be understood as outcomes of a 'pharmaceutical nexus' – that is, a particular configuration of political, ethical, and economic dimensions that interrelate to generate diverse social, moral, and biological outcomes in local settings. As stated by the authors, the notion of 'pharmaceutical nexus' carries analytical value as it constitutes both a method of inquiry and an object of critical investigation; in so doing, it allows a mapping of the role of institutional practices, related to wide political and economic shifts, and jointly consider these in relation to social processes, rooted instead in local moral worlds, in shaping personal agency and imaginaries of illness (ibid:22).

In this chapter, I argue that a deeper understanding of this phenomenon requires reading it as the product of a complex 'psychopharmaceutical nexus' (see Petryna et al. 2006) which has its roots in pharmacological, political, and economic developments concentrated in the Global North, and trace the macro-dynamics that resulted in the psychopharmaceuticalization of the Ugandan refugee emergency. There is a significant gap in the literature examining the political economy of psychopharmaceutical prescription in emergencies, both in Uganda and at a global level, and a dearth of studies that analyse these changes from a multi-scalar and interdisciplinary perspective. Given that this is a complex and growing phenomenon, this chapter aims at contributing to several bodies of literature, namely the study of refugee mental health, global mental health policy, and the anthropology of pharmacology. It draws on, and seeks to establish connections within, a wide range of literature, ranging from an analysis of WHO, UNHCR, and interagency reports and guidelines over the past three decades; ethnographic studies of psychopharmaceutical use in the Global South; global mental health and humanitarian policy research; and clinical studies of public health measures in displacement settings.

I begin by contextualising the prescription of psychiatric treatment in existing guidelines on mental health interventions in emergency settings. I then turn to the dimensions that I argue have shaped the increased relevance of pharmacotherapies in humanitarian interventions over the past two decades. I propose that the heavy reliance of the Ugandan refugee emergency on psychotropic medication should be conceptualized as the product of a psychopharmaceutical nexus resulting from at least three significant processes: a general recent expansion in psychopharmaceutical use across the Global South; significant shifts in global mental health

agendas and their interrelation with humanitarian policy; and finally, Uganda's particular history of mental health and development efforts, which has provided a generative context for the intersection of these dimensions, and which I consider in light of global mental health policy shifts over the past two decades. Having laid out my proposed (and in places, partial) mapping of the configuration of the psychopharmaceutical nexus of Ugandan refugee settings, I conclude the chapter with an overview of the criticisms that have addressed the prescription of psychopharmaceuticals in humanitarian contexts.

2. Contextualising psychiatric treatment in emergencies

The inclusion of psychopharmaceutical treatment as part of emergency interventions is not a new phenomenon. Rather, it seems to have been an integral component of early forms of humanitarian psychiatry, particularly those targeting the mental health of refugees and Internally Displaced Persons (IDPs). Pupavac (2002, 2004) and Summerfield (1999), among others, have criticised the widespread use of psychiatric treatment in psychosocial interventions in the Balkans in the early 1990s; meanwhile, Ibrahim (2021) and Ong (2003:103-05) document instances of psychopharmaceutical prescription to Indochinese refugees, both in Cambodian camps and in the United States, in the early 1980s. Largely, the use of psychiatric drugs in displacement contexts can be noted to chronologically coincide with the rise of the notion of 'trauma' as the dominant empirical paradigm in refugee mental health, and of Post-Traumatic Stress Disorder (PTSD) as the main diagnostic and therapeutic category through which refugees' predicaments and psychological suffering should be understood.

Psychiatric drug use in emergencies was systematised with its formal inclusion in the IASC guidelines on MHPSS (IASC 2007). The prescription of psychiatric treatment in humanitarian settings is categorised by the IASC Guidelines (IASC 2007) as falling under the category of "Specialized services", which the manual places at the top layer of its intervention pyramid (see Figure 1) and which is meant to provide "additional support required for the small percentage of the population whose suffering […] is intolerable and who may have significant difficulties in basic daily functioning" (IASC 2007:13). As opposed to specific interventions and other forms of assistance situated at lower levels of the pyramid, "Specialised services" target specifically people with severe mental disorders and

should be provided by qualified psychologists or psychiatrists. Indications relative to the prescription of psychopharmaceuticals within an emergency response are included in all the main sets of guidelines on mental health support in low-resource settings. The IASC Guidelines (IASC 2007) first included psychopharmaceuticals in 2007; the minimum care package in these contexts, the guidelines state, should include at least one anti-epileptic, one anti-psychotic, one anti-Parkinsonian (to address the frequent side effects of anti-psychotics), one anxiolytic, and one anti-depressant medicine. Subsequently issued manuals, such as those jointly produced by the UNHCR and WHO Mental Health Gap Action Programme Humanitarian Intervention Guide (mhGAP-HIG) (WHO and UNHCR 2015), differ in terms of clinical specificity, but fundamentally adhere to IASC recommendations.

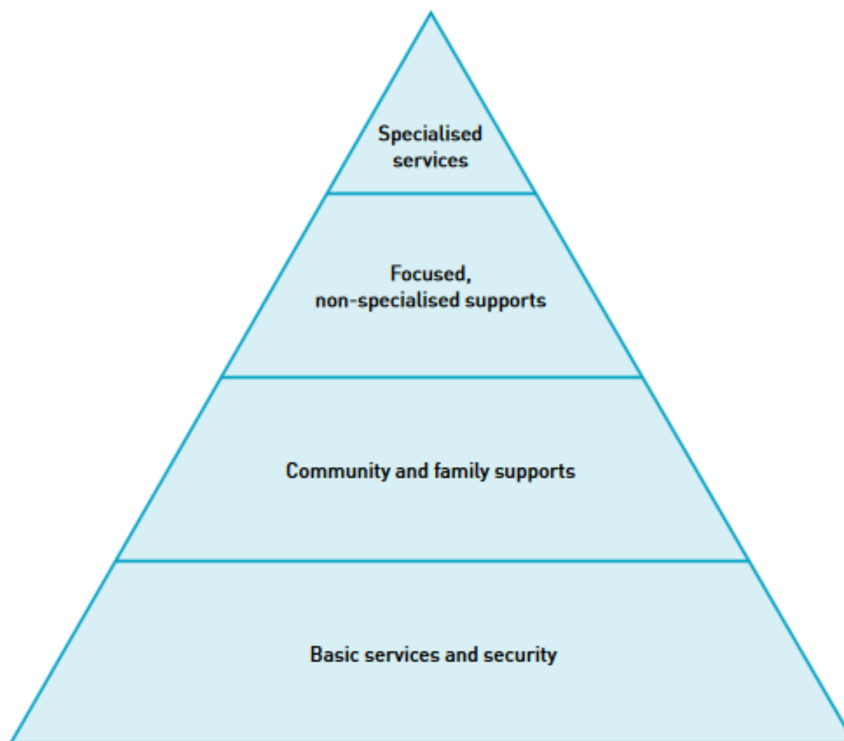

Figure 1. IASC intervention pyramid for mental health and psychosocial support in emergencies. Source: IASC 2007.

From a clinical perspective, the use of psychopharmaceuticals in emergency settings stems from an understanding of people suffering from mental disorders as constituting a particularly vulnerable group in humanitarian contexts. A large body of literature points out that people suffering from severe mental disorders are particularly at risk of experiencing neglect, abuse, and abandonment during an emergency, as well as more likely to be severely impacted by an

interruption in access to health services (Ostuzzi et al. 2017; Charlson et al. 2019). Severe mental disorders can be significantly exacerbated by the stressors of crisis situations; triggered by adversity and disruption, relapses and worsening of symptoms are common (Ventevogel et al. 2015; Jones et al. 2009). Mirroring the inter- and multi-sectoral ambitions of MHPSS interventions, which the guidelines describe as equally belonging to the 'Health' and 'Protection' clusters of humanitarian action, psychopharmaceuticals are framed as both medical and protection tools. This consideration is vital when considering the empirical realities of refugees' experiences of psychopharmaceutical treatment in Palabek (Chapter 7), and particularly the ways in which the prescription of psychopharmaceuticals in this context may often contradict the humanitarian principle of 'Do No Harm'.

It should be noted, however, that the use of psychopharmaceuticals takes up remarkably little room in currently available MHPSS intervention guides. Largely, the consensus emerging from existing MHPSS manuals is that the prescription of psychopharmacological treatment in humanitarian contexts should only concern the limited number of individuals whose acute symptomatology requires a pharmacological aid – especially in the case of those individuals whose severe psychological condition pre-dates the crisis object of humanitarian intervention (see e.g., IASC 2007:13). On paper, existing guidelines caution practitioners against the over-medicalization of suffering in emergency settings, and particularly against the over-use of the category of PTSD and its 'taken-for-granted dimension' (Breslau 2004:114) in humanitarian contexts. This is largely the result of the intense pushback that discussions on the utility and trans-cultural applicability of notions of trauma and PTSD have received from medical anthropologists and transcultural psychiatrists (Chapter 1). The narrative that has emerged from this polarised debate is one in which manifestations of stress in crisis situations should be understood as normal reactions to adversity and disruption, and as such as non-pathological. Diagnostic assessments and pharmacological prescription in the immediate aftermath of these events are strongly discouraged by both IASC and mhGAP guidelines, which openly warn against common assumptions of traumatisation, stating for example: "Do not assume that everyone in an emergency is traumatised, or that people who appear resilient need no support" (IASC 2007:14), and emphasising that "an exclusive focus on traumatic stress may lead to neglect of many other key mental health and psychosocial issues" (ibid:17). Furthermore, the guidelines place significant emphasis on social and environmental models of wellbeing in humanitarian contexts (Miller et al. 2021), which recognise the fundamental role of social stressors experienced in humanitarian settings – such as disruption

of social networks and increases in gender-based violence – in shaping forms of psychological suffering (Batniji et al. 2006; Tol et al. 2011).

In developing the IASC MHPSS guidelines, advocates within the field explicitly set out to establish a less medicalizing, and especially less 'trauma-focused' paradigm in humanitarian psychiatry. These considerations have played a vital role in fostering the development and implementation of cross-cluster interventions aimed at strengthening social networks and the provision of basic services in emergencies. However, a distance from PTSD does not necessarily imply a distance from Western psychiatric frameworks; if the former has been achieved to some extent, at least on paper, and interventions narrowly focused on trauma are starting to decline, the same cannot be said for the latter. Rather, it is important to note that the debate around the arguably excessive focus on trauma and its related syndromes has diverted attention from aspects of the discussion which concern the use of psychiatric categories and biomedical models of suffering in non-Western, low-resource, and crisis-stricken settings. As scholars have shown, the MHPSS field in practice still heavily relies on a psychopathological model of distress, and on individualised, clinical approaches to suffering. Western biomedical categories of mental disorders are still the prevalent measure of distress, as well as the criteria generally used to recruit people to participate in brief forms of therapies. For example, Marshall (2022) notes that MHPSS policy discourse is still deeply embedded in Western biomedical categories and conceptualizations of distress. On the other hand, several studies, reviews, and meta-analyses have shown that MHPSS programmes still largely prioritise individual interventions based on clinical approaches to suffering (e.g., Kerbage and Marranconi 2017; Brown et al. 2017; Chiumento et al. 2017; Tol et al. 2011). Despite the discursive focus on socially oriented and non-psychocentric models of distress, therefore, in practice psychiatric categories are still the theoretical framework informing many MHPSS interventions, and particularly the prescription of psychopharmaceuticals in humanitarian settings. As we will see, psychiatric medications continue to be of deep relevance to interveners in these settings.

Paradoxically, as noted by Van Ommeren and colleagues (2011), the impetus for the expansion of psychopharmaceutical use in the context of humanitarian responses emerged largely from the publication of the IASC guidelines. The growing reliance of emergency responses on psychotropic treatment is demonstrated by the changes in the Interagency Emergency Health Kit (IEHK). First developed over three decades ago, the IEHK is an essential component of public health emergency responses (Hogerzeil 1990), constituted by a

large pre-packed box containing the medications that are thought sufficient to meet the needs of 10,000 people over three months (WHO 2011), and which can be swiftly ordered by humanitarian organizations to meet affected populations' needs in the acute phases of an emergency response. Psychotropic drugs have been included in the IEHK since 2006, but these mostly consisted of anti-epileptic and anti-convulsant medications, while treatment for depression and psychosis was not covered (Van Ommeren et al. 2011). This has changed with subsequent editions of the kit; the introduction to the 2011 edition explicitly lists the expansion of psychiatric medications among the most relevant amendments to the list (WHO 2011:7). The expansion of psychopharmaceutical use in emergencies is particularly evident in the latest edition of the IEHK, issued in 2017, which includes eight psychotropic medications: one anti-Parkinsonian (Biperiden), one anxiolytic (Diazepam), two antipsychotics (Haloperidol, in both tablet and injection form), one anti-depressant (Fluoxetine), and three anti-epileptics (WHO 2017).

Therefore, despite divergent debates about their appropriateness, the increased relevance of psychopharmaceuticals in the context of humanitarian responses is therefore an established clinical and social reality. This phenomenon, I argue, emerges from recent transformations of the global pharmacological, developmental, and humanitarian landscape, and cannot be understood in isolation from wider political and economic shifts in development and health policy over the past decades. In the rest of this chapter, I analyse some of the dynamics that, at both the global and the Ugandan level, I identify as particularly significant in shaping the growing reliance of humanitarian efforts on psychiatric treatment.

3. The psychopharmaceutical expansion in the Global South

From the beginning of modern psychopharmacology in the early 1950s, when psychotropic medications were first synthesised, psychopharmaceuticals have known an extraordinary growth (Braslow and Marder 2019). Their impact on therapeutic trajectories and social imaginaries of mental illness in Europe and North America can hardly be overstated; the antipsychotic chlorpromazine was often hailed as a 'miracle drug' (Ban 2007), while the prescription of antidepressants took place on such a wide scale that the last decades of the 20th century have sometimes been referred to as the 'Prozac era' (Shorter 2014). The role of pharmaceutical companies in furthering this increase cannot be underestimated (Horwitz and

Wakefield 2007; Bracken et al. 2012). Indeed, scholars have denounced the role played by the pharmaceutical industry in producing demand for psychiatric medication through their imbrication in the marketplace (Petryna et al. 2006; Raikhel 2013; Bracken et al. 2016). Studies have shown how companies have invested significant resources in effectively marketing specific conditions (e.g., anxiety disorder, major depression, and panic disorder) through clinical trials, academic publishing, and popular discourse to manufacture the need for their products (Healy 2006; Van der Geest 2006). These strategies have been widely successful. In the UK, antidepressant prescriptions rose by 10% every year between 1998 and 2010 (Moncrieff 2017); between 2014 and 2017, 9% of the UK population, and 12.7% of Americans over 12 years old, including one in four women over 60 years of age, reportedly took antidepressant medications (Lewer et al. 2015; Pratt et al. 2017). Recent public scandals, such as the one surrounding the onset of the opioid epidemic in North America (e.g., Sarpatwari et al. 2017) have drawn attention to dubious, though not illicit, practices on the part of pharmaceutical companies in marketing their products. However, despite their wide diffusion, the marketization of psychopharmaceuticals has rarely come under the same kind of scrutiny and has elicited scarce public activism.

While the popularity of psychopharmaceuticals was initially limited to Euro-American contexts, however, attempts to export psychotropic medications to the rest of the world soon followed. One of the first major steps in this direction dates back to 1977, with the inclusion of psychopharmaceuticals in the first issue of the World Health Organization's Essential Medicines List (EML). Psychiatric medications mentioned in this first WHO EML included antidepressants (amitriptyline), antipsychotics (haloperidol, fluphenazine, chlorpromazine), tranquilizers (diazepam), antiepileptics, and mood stabilizers (lithium carbonate) (WHO 1977); the list was updated and expanded every two years, with every subsequent version of the document (Ecks 2017). The inclusion of psychopharmaceuticals in the EML constituted a significant turning point in their expansion in low- and middle-income countries, constructing psychotropic treatment as 'essential' and 'beneficial' (Mills 2017). By defining psychotropic drugs as a crucial medical resource for which global availability should be ensured by WHO Member States, the EML provided therefore a significant policy base for the globalization of psychiatric treatment. Indeed, building on assumptions of necessity and efficacy of psychiatric treatment, subsequent WHO resolutions, such as the more recent Mental Health Gap Action Programme (mhGAP) (WHO 2008) and Mental Health Action Plan 2013–2020 (WHO 2013) advocated for improved availability of psychiatric treatment. This would later

be expanded to emergency interventions; the afore-mentioned Interagency Emergency Health Kit explicitly relied on the EML (Van Ommeren et al. 2011).

If the circulation of psychopharmaceuticals in the Global South is not an entirely new phenomenon, however, over the past two decades the prescription and use of these medications in low- and middle-income countries across the Global South has been undergoing an unprecedented expansion (Ecks 2017; Petryna et al. 2006). Over a decade ago, scholars such as Good (2010) and Marrow and Luhrmann (2012) have cautioned from assuming the existence of a global hegemony of psychopharmaceuticals, noting that though an expansion was under way, it was far from being evenly distributed. This remains true today, and here I do not wish to suggest that psychiatric medicine is equally marketed, available, and prescribed everywhere in different contexts across the world; however, over the past decade the circulation of psychopharmacological technologies has grown significantly and it is worth analysing. Recent data published in *The Lancet* indicate that the highest relative growth in psychopharmaceutical use between 2008 and 2019 took place in lower-middle-income countries across the Global South (Brauer et al. 2021). Data for low-income countries is not yet available in international databases, likely mirroring the early stages of this trend; however, it is worth noting that, as shown by Ecks (2014), the circulation of psychopharmaceuticals in the Global South often takes place outside of institutional public health channels and is thus generally less likely to be captured by official statistics. Qualitative and – particularly – ethnographic studies have often been noted to be vital in the analysis of local manifestations of global policy shifts (Jain and Orr 2016), and thus become particularly relevant in the examination of on-the-ground realities of this unfolding phenomenon.

In recent years medical anthropologists have noted a remarkable growth in psychopharmaceutical use in the Global South. For example, Ecks (2014, 2017) showed a sharp increase in private sector prescriptions of psychotropic drugs in India. In post-war Liberia, Abramowitz (2010) noted that antidepressants were often incorporated within local healing systems. In Iran, scholars have observed a growth in prescription of mood stabilizers and anti-psychotics in the aftermath of the revolution (Parkinson and Behrouzan 2015), while in post-insurgency Indonesia Del Vecchio-Good (2010) noted the mass introduction of psychopharmaceuticals in the context of local humanitarian responses. Authors have also noted particular risks associated with the prescription of psychotropic treatment in low-resource settings, as in these contexts psychopharmaceuticals are more likely to be prescribed

in experimental dosages and 'polypharmaceutical' combinations (Good 2010), and by primary health care workers or unlicensed professionals rather than psychiatrists (Ecks and Basu 2014), thus outside of psychotherapeutic relationships (Davis 2018). Furthermore, anthropological studies have noted that the expansion of psychiatric medication is often linked to wider socio-political processes and economic shifts. In several contexts such as economic crisis-ridden Greece (Davis 2018), Brazil (Biehl 2010), Chile (Han 2012), Argentina (Lakoff 2005), Vietnam (Tran et al. 2020), and post-conflict Uganda (Branch and Yen 2018), increases in psychopharmaceutical use have closely accompanied the onset of neoliberal economic reforms, and have often emerged in the void left by state withdrawal of public health funding (Davis 2018). Davis conceptualizes this historical sequence as characterised by "deinstitutionalization, pharmaceuticalization, [and] responsibilization" (2018:6). In the Global South, processes of deinstitutionalization of limited psychiatric care, which attempted to scale-down the role of psychiatric hospitals in favour of community-based settings, have often coincided with neoliberal defunding of public health infrastructures (Ecks 2017), configuring the management of care on individual self-medication through pills and increasingly shifting therapeutic responsibility upon individuals (see also Esposito and Perez 2014).

4. Global mental health, development, and humanitarian intervention

On top of the rising influence of the pharmaceutical industry, particularly within the context of a public health infrastructure void created by neoliberal economic policies, the psychopharmaceutical expansion in the Global South has been accelerated by increases in global mental health efforts over the past decade (Davis 2018). Mills (2017) has pointed out that the rationale behind the inclusion of psychopharmaceuticals in the Essential Medicine List has its roots in the same discursive justification which supported the establishment of psychiatric institutions under colonial rule – that is, a narrative centred around a fundamental universality of mental disorders, and evoking a moral and ethical obligation to provide mental health care where it is missing, in the name of a shared humanity (Keller 2007; Cohen 2021).

The same moral economy underlies the logic of global mental health, a field which over the past fifteen years has been catalysing ever-growing attention and financial resources. Indeed, global mental health proponents have long framed the field's goal to alleviate the global

burden of mental health problems as a 'moral imperative' (Bemme and D'Souza 2014), while medical anthropologist and global mental health advocate Arthur Kleinman famously described the very existence of a 'treatment gap' in mental health worldwide as "a moral failure of humanity" (2009:604). To bridge the existing gap between those in need of psychological care and the limited assistance available in low-resource settings, advocates within the field have often called for the scaling-up of 'evidence-based' mental health interventions (Tol et al. 2020; Patel et al. 2011). Particularly in its early years, global mental health scholarship has largely framed psychopharmaceuticals as the gold standard for evidence-based interventions, pushing for improved access to psychiatric medication in low- and middle-income countries (e.g., Lancet Mental Health Group 2007; Patel et al. 2014; Padmanathan and Rai 2016). These ideas have had widespread ramifications, particularly amongst international health policy hubs such as the WHO, whose discourse on mental health care in low- and middle-income countries has largely incorporated global mental health statistics and approaches (Littoz-Monnet 2022).

Widespread ethical, clinical, and political concerns have been voiced around the normalization and increasing prescription of psychotropic treatment in the Global South, expedited by global mental health interventions. Authors have noted the paradoxical timing of this upward trend, unfolding at a time in which the popularity of psychiatric medications in high-income countries is steadily declining (Davis 2018; Mills 2014). Indeed, the last decades have seen increasing pushback against the use and prescription of psychiatric treatment in the Global North (Bracken et al. 2012). Resistance against psychoactive medication ranges from grassroot networks such as "user" and "survivor" movements, denouncing the ways in which psychopharmaceuticals can be used to violate human rights, to the rise of therapeutics explicitly oriented towards non-pharmacological, 'recovery'-based frameworks (Cox and Webb 2015; Giordano 2014). The evidence for the efficacy of psychiatric drugs has often been questioned, too, with several authors pointing out that global mental health retains significant ties with the pharmaceutical industry (e.g., Littoz-Monnet 2022; Fernando 2011; Lovell et al. 2019). Several studies convincingly argue that psychopharmaceuticals often work no better than placebo, showing that rates of recovery from mental disorders are higher where no 'technical' treatment is used (Luhrmann et al. 2015; Middleton and Moncrieff 2019; Bracken et al. 2016). On the other hand, the detrimental side-effects and stigma associated with long-term reliance on psychiatric treatment seem to have been severely understated (Bemme and Kirmayer 2020; Read 2012).

These critiques, however, have carried limited weight as far as global mental health practice is concerned; rather, as Ecks (2017) notes, the only aspect they managed to significantly affect was the field's public and policy discourse. Over the past decade mentions of psychopharmaceuticals have almost disappeared from UNHCR and WHO programmatic documents. Global mental health and humanitarian psychiatry, meanwhile, have significantly scaled back the use of pathologizing and biomedically rooted language, and in recent years efforts in these fields have mostly focused on short-term, non-pharmacological psychological interventions. Several of these, such as those known as 'Friendship Bench' (Chibanda et al. 2016), 'Problem Management Plus (PM+)' (Dawson et al. 2015), and 'Self Help Plus (SH+)' (Tol et al. 2020), have been readily included in WHO packages and are often employed in emergency settings (see Chapter 5). However, as several authors have noted, psychiatric medications still feature prominently in global mental health interventions worldwide (Bemme and Kirmayer 2020; Kienzler 2019) and are becoming particularly widespread in humanitarian psychiatry (Jones and Ventevogel 2021; Van Ommeren et al. 2011; Silove et al. 2017).

Reflecting on this discrepancy, Ecks (2017) has distinguished between the 'public' life of psychopharmaceuticals – emphasized in global policy discourse – and a 'private' one, which instead reflects the real circulation of psychiatric medication. He points out that global mental health's apparent shift away from psychopharmaceuticals does not necessarily reflect the 'on the ground' realities of interventions, but rather a strategic policy response to vocal pushback against psychoactive medications. In this sense, the inclusion of non-pharmacological interventions has merely broadened the available toolkit; the dominance of psychopharmaceuticals in daily clinical practice, on the other hand, has remained unchanged. Despite their quasi-invisibility in policy discourse, therefore, psychopharmaceuticals lead intense 'private lives' (Ecks 2017) in the Global South.

The expansion of psychiatric medication across the Global South – and particularly in humanitarian emergencies – has been largely facilitated by global mental health efforts towards the integration of mental health into primary health care services in low- and middle-income countries, and particularly in humanitarian emergencies. In its most basic delineation, integrating mental health into primary health care entails training primary care workers in low- and middle-income countries in the identification, management, and referral of patients suffering from psychological conditions (WHO 2008). While the idea has been at the core of primary health approaches since the 1970s (Ventevogel 2014), it gained renewed and

significant traction with the growth of the field of global mental health, which promptly incorporated it in its agenda (Bemme and D'Souza 2014). Global mental health advocates have long pushed for policy shifts in this direction, arguing that the integration of basic mental health services within existing primary health ones would make mental health assistance widely "accessible, affordable and acceptable" to local populations in the Global South (Funk et al. 2008:6).

The emphasis on mental health integration in primary care stems from a realization that the dearth of mental health professionals in low- and middle-income countries would make the expansion of mental health care provision an impossible task, were it to rely exclusively on trained psychiatrists and mental health staff (Saxena et al. 2007). Notions of 'task-shifting' – the process of delegating tasks usually performed by specialists to health workers with different (and generally lower) levels of training – and the goal of decentralising psychiatric care were central to this proposal; incorporating mental health services into primary health services promised the possibility and feasibility of extending mental health coverage to rural and under-served areas in low-resource settings, and beyond psychiatric institutions (Ventevogel 2014). In this sense, the integration of mental health into primary health structures presented itself as a core aspirational feature of global mental health – not least because of its pragmatic overtones, which made it amenable to policymakers. As noted by Bemme and D'Souza (2014), however, the focus on the incorporation of mental health within primary care, as well as the emphasis on task-shifting, served not only as programmatic but also as strategic elements in the construction of the field of global mental health, upholding the universality of mental disorders and thus complementing and strengthening the logic of the 'treatment gap'.

The project generated significant enthusiasm amongst donors and decision-makers in public health policy hubs, at a time in which mental health was steadily rising on international development agendas; the integration of mental health into primary health care, and the related idea of task-shifting, were quickly identified as one of the five 'grand challenges' in global mental health in the field's early years (Collins et al. 2011), and remain a global priority under the recent 2023 WHO World Mental Health Report, which lists them as one of its main pillars (Barbui 2022; Freeman 2022). Within a few years, the WHO developed an operational strategy known as the Mental Health Gap Action Programme (mhGAP) which, in alignment with global mental health logics and principles, is aimed at scaling up services targeting the 'treatment gap' in mental, neurological, and substance use disorders (MNS).

Guidelines known as the mhGAP Intervention Guide (mhGAP-IG) were widely exported and used as a set of guidelines to train thousands of health workers in low- and middle-income countries (WHO 2008). This policy move, however, also significantly increased the number of professionals able to prescribe psychotropic medication.

Soon after, the idea seeped into humanitarian policy, which over the past few decades had become increasingly focused on the psychological needs of crisis-affected populations, leading to the creation of the sub-field of mental health and psychosocial support interventions (MHPSS) in emergency settings (Jones and Ventevogel 2021). With 117 million people projected to be displaced by the end of 2023 (UNHCR 2023),[48] the search for sustainable solutions for displaced populations has never been higher on international political and development agendas. The integration of mental health into primary health services was thus streamlined in hundreds of refugee situations, around 756% of which are located in low- and middle-income countries (ibid.), and where since 2009 the United Nation High Commissioner for Refugees (UNHCR) had been collecting data around MNS conditions. Since 2015, the mhGAP Humanitarian Intervention Guide (mhGAP-HIG), a version of the WHO guidelines adapted for humanitarian contexts, has been used by the UNHCR to train humanitarian workers in the identification and clinical management of mental disorders in hundreds of refugee situations worldwide (WHO and UNHCR 2015; Fine et al. 2022). As pointed out in Chapter 1, furthermore, humanitarian emergencies constitute significant sites for the design and implementation of global mental health policy, which produces here the figures which justify its rationale.

5. Why here, why now? Uganda's global mental health journey

Efforts to incorporate mental health care in displacement settings have targeted particularly refugee-hosting countries in Sub-Saharan Africa (Echeverri et al. 2018; Fine et al. 2022), including Uganda, which since 2018 is the site of a UNHCR-coordinated project to integrate mental health into primary health services in refugee settings. This means that low- and mid-level Health Centres in the thirty refugee settlements across the country now include a Mental

[48] Displaced people, as per the most recent definition by the United Nations High Commissioner for Refugees (UNHCR), include refugees, asylum seekers, internally displaced people (IDP), and other people in need of international protection (UNHCR 2022b).

Health ward, where the severely under-resourced psychiatric officers and nurses often rely on the prescription of psychopharmaceuticals.

At least two sets of reasons underlie Uganda's inclusion in this policy shift, which arguably places the country at the forefront of global mental health and development policy innovation. On the one hand, Uganda's role in the global forced migration crisis is significant, as the country currently hosts over 1.5 million refugees, making it the largest host country in Africa and the fifth biggest worldwide (UNHCR 2022b). The sheer scale of this event justifies a significant investment in the country's infrastructure to deal with the refugee crisis – particularly as, over the past decades, the increased securitization of countries in the Global North has dramatically reduced chances for refugee resettlement, making the search for durable solutions in host countries a global priority (Hansen 2018).

However, Uganda's long history of implementing psychological programmes (see Chapter 1) can be understood as having played an important role in leading to the current psychopharmaceuticalization of the country's current refugee response. Due to the legacies of HIV/AIDS counselling and war-related trauma interventions (Meinert and Whyte 2020), Uganda has been on the radar of global mental health policymakers since the field's early days, and arguably played a fundamental role in the construction of global mental health's knowledge and practice base. This can be understood as intimately related to the country's history, both in terms of violent events and of local familiarity with forms of interventions aimed at healing the self through individual therapeutic and pharmacological interventions (Meinert and Whyte 2020). As figures related to trauma and PTSD raise the profile of global mental health and encourage investments in related interventions (Hinton and Good 2016:10), the existence of an infrastructure set up to deal with post-conflict trauma often represents a gateway for the introduction of global mental health interventions and policy. Indeed, in 2002 Uganda was the site of the first randomised psychotherapy clinical trial ever conducted in Africa, carried out by Paul Bolton and colleagues (Bolton et al. 2003). Bolton and colleagues' trial of group interpersonal psychotherapy had incredible resonance; widely regarded as the first evidence-based global mental health intervention, it was often used by global mental health advocates to demonstrate the feasibility of culturally adapted forms of psychotherapy in the Global South, and as indication of the need to scale-up evidence-based interventions (Carlson et al. 2018; Patel et al. 2018).

These factors identified the country as an ideal setting for showcasing global mental health interventions. That same year, efforts to integrate mental health into primary health care services across Uganda began, and the first steps to equip low-level health facilities across the country with psychopharmaceuticals were taken (Yen 2018). For the following two decades, the Ugandan government has continued to pursue the integration of mental health into primary care services, piloting several different plans aimed in this direction (see e.g., Kigozi et al. 2016; Kigozi and SSebunnya 2009). Between 2011 and 2019, Uganda was one of few countries targeted by the Programme for Improving Mental Health Care (PRIME) and the EMERALD Project, to date some of the most ambitious global mental health endeavours which sought to scale-up mental health assistance by integrating psychiatric care in primary health care structures (see e.g., Lund et al. 2012; Thornicroft and Semrau 2019).

It is worth noting that none of these projects have resulted in a definite pathway for a country-wide mental health system reform; rather, Uganda seems to serve as a perennial testing ground for global mental health interventions. As many of these studies note, Uganda keeps struggling with a lack of funding devoted to mental health (Kigozi et al. 2010, 2016), as well as with the practical implementation of this measure at district and community level, where the lack of financial and human resources is most keenly felt (Mugisha et al. 2016). Given that currently only between 1% and 3% of the national budget is being channelled into mental health in Uganda (WHO 2020), external development grants have proven to be the most reliable source of mental health funding (Ssebunnya et al. 2018). Uganda's continuous role as a testing ground for global mental health projects can therefore be explained through the country's contingency on external funding in the face of a lack of political will to invest in mental health.

The latter has lately been made apparent by widespread critiques to the recent and long-awaited publication of a new National Mental Health Act (Government of Uganda 2018). While the new Act finally repealed the "outdated and offensive" legislation (Kigozi et al. 2010:2), developed in colonial times and effective since 1964, the newly issued statute has been widely pointed out as still heavily reliant on psychiatric pharmacological treatment and hospitalizations (CEPIL n.d.) – from both of which, current global public and global mental health discourses have sought to distance themselves (e.g., WHO 2022; Barbui 2022). This should generate serious doubts as to whether the country is actually on a progressive pathway towards a better, recovery-oriented and user-centred mental health system, outside of the context of emergencies. In the absence of clear political efforts to improve the national

mental health system, Uganda's quasi-exclusive dependence on development funding entails adhering to the latest (and often shifting) global mental health agendas – including the recent mainstreaming of psychopharmacological interventions in refugee settings.

The dependency on global mental health funding may partly be a politically strategic choice. As several authors have emphasized, mental health policy efforts in Uganda historically carry strong political overtones and have been unfolding within the widespread neoliberal reforms that the country has been undergoing since President Museveni seized power in 1986 (Vorhölter 2021; Yen 2018; Branch and Yen 2018). Vorhölter (2021) has noted that psychological and therapeutic vernaculars have come to increasingly permeate the popular imaginary, particularly amongst middle-class Ugandans. Indeed, mental health discourse in Uganda has become deeply entrenched with government development agendas. Pro-government media often discuss mental health issues – for example, by proudly announcing that the country is "on track to achieve universal mental health coverage" (Mutegeki 2019). Mental health expertise has also significantly expanded in the country over this time; while Uganda is still considered among the least equipped in the world in terms of psychiatric care, WHO data shows that between 2014 and 2020 the number of mental health professionals operating within the country has tripled (WHO 2020). With the recent inclusion of mental health among the Sustainable Development Goals in 2016 (Mills 2018), the country's willingness to amplify global mental health discourse by hosting a variety of pilot interventions may well be considered instrumental in safeguarding the country's status as a donor darling of development funding. This long-held reputation has recently come to be questioned on the basis of the government's increasingly apparent authoritarian tendencies and worrying human rights record (Wiegratz et al. 2018; Human Rights Watch 2021), particularly apparent in the signing of the punitive 'Anti-Homosexuality Bill' in early 2023 (Human Rights Watch 2023).

In light of these complex and interrelated dynamics, therefore, Uganda's refugee crisis seems to have become a way to help channel the reform that the country has been pursuing for at least two decades. The influx of over a million South Sudanese refugees who began entering the country in early 2017 fleeing a brutal civil war has once again allowed for mental health reforms to be introduced, and for mental health care to be integrated in primary health infrastructures in refugee settlements across Uganda. This shift means that mental health workers, and particularly psychiatric nurses and officers, now operate in low-level Health Centres in refugee settlements across the country and often rely on the prescription of

psychopharmaceuticals (UNHCR 2019), significantly expanding this element of the humanitarian response. When interviewed about this policy, which establishes a permanent psychiatric presence in refugee settlements, UNHCR Health Officers in Kampala expressed hopes that this would help establish a 'holistic system' able to address both mild and severe psychological distress, thus easing the significant public health costs involved in referring refugees to facilities and structures outside of the settlements. However, they also highlighted the possibility that this shift in refugee management might carry implications for Ugandan's national mental health system as well: *"If we can demonstrate that this works to the Ministry of Health, this is something that could be applied to the whole country"*, one UNHCR officer explained to me.

This innovation was introduced at a moment in which international attention towards refugees' mental health had made the widespread psychological distress in Ugandan refugee settlements the object of pressing concerns. Institutional reports emerged, estimating refugees' depression rates as about ten times higher than Ugandans, and identifying over three quarters of refugees as in need of mental health assistance (Government of Uganda and UNHCR 2022). Signs of individual and social affliction among refugees were emerging as rampant, leading to sharp increases in suicidal attempts – both failed and successful (Bukuluki et al. 2021; Bwesige and Snider 2021).[49] However, as mental health interventions in humanitarian settings have historically mostly consisted of short-term therapy (see e.g., Chapter 5), or in forms of counselling aimed at 'soft-skill' training, the institutionalization of psychiatric care in refugee settlements also signals a decisive shift towards the medicalization of distress experienced by refugees, as well as other crisis-affected groups. In Uganda, psychiatric care providers are usually based at regional referral hospitals; with the integration of mental health care in primary health structures in refugee settings, the concentration of psychiatric and mental health services and professionals in Palabek refugee settlement is more than double that of the rest of the country,[50] albeit subject to the same underfunding that characterises the country's refugee response.

[49] It is worth repeating here that, as noted in Chapter 2, the issue is so severe that today Uganda is one of the only refugee-hosting countries to have a dedicated 'Suicide Dashboard' on UNHCR and other humanitarian databases (see e.g., UNHCR 2022).
[50] According to WHO data, with a budget allocated for mental health accounting for 1% of public funds, and about thirty-two psychiatrists for over forty-five million inhabitants, Uganda is still among the least equipped in the world in terms of psychiatric care (WHO 2017).

As the integration of mental health care into primary care services notably constitutes one of the pillars of the field of global mental health (e.g., Patel et al. 2013), this shift represents a powerful testimony to the increasing influence of the field on policy and practice in low- and middle-income countries, and its recent establishment as a recognized actor in the humanitarian policy arena (Bemme and Kirmayer 2020).

6. Emerging failures of integrated mental health care: medicalization, disengagement, and the inadequacies of the 'treatment gap'

However, the integration of mental health within primary health care structures is far from unproblematic. As this chapter has shown, the sporadic use of psychiatric medication within emergency aid delivery has been a component of refugee assistance since the mid-1980s (Ibrahim 2021). The integration of mental health care within primary health care in refugee settings constitutes a structural change in the status of psychopharmacological therapies in emergencies, as it expands the prescription of psychiatric treatment beyond discrete and often volatile NGO programmes, effectively institutionalising the availability of psychopharmaceuticals in humanitarian contexts (Pérez-Sales et al. 2011; Tarannum et al. 2019). This has important consequences; in a seminal article which laid the grounds for studies of the 'social lives' of medicine, Van der Geest and colleagues observed that "the availability of medicines affects how practitioners and patients deal with sickness" (1996:157). The institutionalisation of psy-expertise and the expansion of psychopharmaceutical availability in these contexts, often leads to an increase in diagnosis production, allowing for the increased medicalization of distress among displaced populations (Beeker et al. 2021).

While the integration of mental health care in primary health settings has the potential to facilitate access to services for people in dire need of care, medical anthropologists and transcultural psychiatrists have warned that it may result in widespread medicalization – a process through which social or systemic issues such as chronic poverty, political oppression, alcoholism, and gendered forms of violence, are framed as medical problems and treated as such (Clark 2014; Jansen et al. 2015). While policymakers often depict emergency situations as "ripe opportunities to build sustainable mental health services" (Epping-Jordan et al. 2015:2), and thus accelerate development processes, several scholars have warned against the

widespread medicalization of psychological suffering that the prescription of psychopharmaceuticals in low-resource and crisis-stricken settings may entail (Ingleby 2014).

Notably, Peter Ventevogel, a senior UNHCR mental health officer and a vocal MHPSS advocate, lucidly warned against this risk during the early stages of the push towards the integration of mental health care into low-resource primary health settings (Ventevogel 2014). He identified the danger of medicalization as emerging from three main characteristics of the WHO mhGAP programme: the reliance of the mhGAP guidelines on strict biomedical categories, especially for diagnoses such as depression or anxiety, for which a genetic or biologic basis has not been identified; the assumed universality of mental disorders across cultures, which the mhGAP programme upholds; and finally, the reality of clinical practice, which Ventevogel warns may often be limited to the distribution of psychiatric medication. Indeed, the mhGAP guidelines have been noted to be over-reliant on psychotropic drugs (Mills 2022), and to be tailored to psychiatric frameworks that encourage the standardization of psychological distress (Kirmayer and Pedersen 2014). Corroborating these claims, a recent review of funding streams supporting MHPSS interventions found that the vast majority of financial resources are being channelled into supporting the use of psychotropic medications, rather than community-based and non-pharmacological interventions (Hillel 2023).

Despite these and other warnings about the risks of integrating mental health into primary health care in resource-poor settings, however, the result of these policy shifts seems largely to consist in a sharp increase in psychopharmaceutical prescription. Over the past decade, a large number of studies has shown that, while in theory the integration of mental health care within refugee primary health care services prioritises non-pharmacological approaches, in practice psychotherapeutic interventions are frequently side-lined, and these efforts often translate in the wide prescription of psychopharmaceuticals (Hijazi et al. 2011; Davis 2018; Ventevogel et al. 2012; Hillel 2023). In part, this may be contingent on lack of appropriate funding for mental health staff and infrastructures. In their ethnography of a community mental health program in rural India, Jain and Jadhav have noted that in the absence of sufficient resources psychosocial interventions remain “unrealized policy principles” while mental health care is reduced to the distributions of pills, and aptly described this phenomenon as “administrative psychiatry” (2009:61). Despite practitioners’ best intentions, therefore, the scarcity of resources that characterises the settings where the integration of mental health in primary health care is attempted often poses an obstacle to anything that may require more time than the prescription of psychopharmaceuticals. This is particularly

relevant in refugee settings, where resources are often already significantly stretched, and the budget devoted to mental health largely insufficient to meet the needs of affected populations (Silove et al. 2017; Ventevogel et al. 2015).

On top of critiques originating from the social sciences, however, emerging clinical evidence indicates that the integration of mental health into primary health care structures "may not be the panacea solution initially predicted by the global mental health field" (Cohen 2021:309; see also Mutamba et al. 2013). In particular, despite its promise to represent "a major advance in access to evidence-based and contextually appropriate mental health services" (Ventevogel 2014:671) for refugee and global mental health, the integration of mental health within primary health care in displacement settings seems to have been largely unsuccessful, and to have led to various manifestations of people's disengagement with services (Wagenaar et al. 2022; see also Adaku et al. 2016; Tempany et al. 2009; UNHCR 2023).

Two recent studies are particularly worth mentioning in this respect. Kane and colleagues' (2014) analysis of the UNHCR's Health Information System in 90 refugee camps in fifteen low- and middle-income countries found that refugees' visits to primary health care services for MNS conditions between 2009 and 2013 had been particularly low, and mostly attributable to epileptic and seizure-related issues, suggesting that most common mental health disorders have largely remained unaddressed (e.g., depression, anxiety, and other emotional disorders). The study proposed that the issues lay in the inadequate preparation of humanitarian workers in the identification of mental disorders and called for an intensification of clinical assessment and diagnostic trainings. An even more methodologically ambitious update of this study was recently published by Fine and colleagues (2022). This time, the authors tracked displaced populations' engagement with mental health in primary health services in 175 refugee settings across 24 low- and middle-income countries between 2009 and 2018. Their data shows once again that in most of these settings the rates of refugees consulting mental health services remain extremely low, and especially so in the case of common mental disorders.

Discussing the results of their study, Fine and colleagues hypothesise that the reason underlying such low engagement rates may lie in "differences in illness beliefs and health-seeking behaviours for emotional distress and substance use problems compared to neurological and psychotic disorders" (2022:10). The authors advocate for *more* efforts toward the integration of mental health care in resource-poor – and particularly displacement

– settings. In this sense, their study upholds arguments such as those that I have discussed in Chapter 1, which envisage the 'cultural adaptation' of interventions as the key to cross-cultural implementation.[51] Despite the less than encouraging findings they present, Fine and colleagues' conclusion is unsurprisingly in line with UNHCR's Global Strategy for Public Health 2021 – 2025 (UNHCR 2021), which lists the integration of mental health care in refugee settings as one of its main priority actions. UNHCR's efforts to train primary health care workers in the treatment of mental health care are demonstrably accelerating, with over 1,330 health workers in refugee settings in DRC, Ethiopia, Jordan, Kenya, Niger, Rwanda, South Sudan, Sudan, and Uganda trained with the mhGAP-HIG in 2021 alone (Fine et al. 2022), with the goal of closing the 'treatment gap' in mental health in low-resource and displacement contexts.[52]

These operations are likely to result in significant and concerning increases in psychopharmaceutical prescriptions in low-resource contexts, and thus in the furthering of a psychocentric understanding of refugees' wellbeing. Furthermore, emerging evidence presented here suggests, however, that this may be a case of vast financial and operational resources being channelled towards interventions that elicit little interest in the people who are supposed to benefit from them. A growing body of literature shows that in settings across the Global South people often understand symptoms of distress and common mental disorders as social problems, rather than medical ones (see e.g., Ventevogel et al. 2013; Tran et al. 2020; Esponda et al. 2022), and advocate for a broader consideration of the role of structural, political, and economic factors in shaping people's understandings and experiences of affliction. This growing body of literature indicates that, while proponents of global mental health are pushing for better ways of implementing interventions aimed at closing the 'treatment gap', the reason for people's low engagement with mental health services may lie in incorrect assumptions embedded in the concept of 'treatment gap' itself (e.g., Jansen et al. 2015; Ingleby 2014; Roberts et al. 2022).

The notion of 'treatment gap' stipulates that the lack of individual psychological services that should be addressed through global mental health interventions directly responds to a need

[51] It is worth reiterating here that, as discussed in Chapter 1, these efforts are often limited to forms of 'thin' cultural adaptation, and rarely do they seem to go beyond mere attempts of translation of psychiatric categories into local languages (Anakwenze 2022), thus often reifying notions of culture (Kirmayer 2012).
[52] In this instance, the interrelation and mutual relationship of research and policy emerges again, as another example of the circularity of knowledge production in global mental health, aptly described by Littoz-Monnet (2022) as particularly relevant in the constitution of the field.

that service users feel in their daily lives. However, the fundamental challenge concerning both the nature and the implications of mental health interventions in resource-poor settings appears to be constituted by their limited relevance to the practical circumstances in which people's lives are embedded, and which shape the meanings of their afflictions, as well as their priorities and future possibilities. To be clear, this point is not new, instead echoing arguments at the very core of debates around concepts of trauma and PTSD in the 1990s and early 200s, put forward by medical anthropologists and critical social scientists (see e.g., Summerfield 1999; Bracken et al. 1995; Kienzler 2008; Argenti-Pillen 2000). These criticisms have largely fallen flat; however, as the data collected by UNHCR over more than a decade suggests, there is evidence that that problems they highlighted have remained unchanged. Nevertheless, psychocentric interventions that ignore the role of socio-economic and structural determinants of suffering keep being implemented. In addition, the rise of influence of global mental health in humanitarian policy increasingly allows for the expansion of psychopharmaceutical markets and prescription in refugee settings – particularly so across the Global South. Meanwhile, interventions that address refugees' psychological needs as defined 'from below' – that is, centring people's experiences, priorities, and understandings of their own affliction and its meanings, remain all but absent in global mental health policy (Jain and Orr 2016).

The lack of interventions tailored on people's subjective experiences can be read as a direct manifestation of global mental health's often noted tendency towards 'epistemic injustice' (Cox and Webb 2015; Bemme and Kirmayer 2020; Varma 2016), an instance of cultural erasure in which one form of knowledge is validated over another, which is instead denied legitimacy. This results frequently in the imposition of Western psychiatric epistemologies on already marginalised systems of knowledge and practices, leading to a "silencing of culture" (Montenegro and Ortega 2020), and to the reproduction of colonial systemic dynamics which allow biomedical forms of knowledge to dominate (Rivera-Segarra et al. 2022). Global mental health's assumption of the universality of mental disorder, rooted as it is in biomedical psychiatry, plays an important role here, shaping imagined therapeutic outcomes, as well as the realities of the interventions delivered.

The domination of Western biomedical systems of knowledge and forms of practice, however, also reflects and contributes to the production of a gap in the global mental health literature evaluating the design and implementation of interventions – that is, the dearth of studies investigating first-hand experiences of people living with various forms of

psychological affliction. The lack of in-depth, experience-near, and longitudinal research exploring people's subjective experiences of distress has been remarked by several scholars in recent years (see e.g., Jain and Orr 2016; Jenkins 2015; Myers and Yarris 2019). Yet, the first step to counteract hegemonic, top-down, and universalistic arguments around global mental health frameworks and treatment models must necessarily originate from the centring of people's lived worlds in the production of "engaged anthropology" (Ortner 2015). Similarly, arguments for what works and what does not in global mental health must foreground phenomenological experiences of affliction and understand them within the local moral and socio-cultural worlds in which people's lives are embedded.

7. Conclusion

The increasing reliance of humanitarian responses on psychotropic medication is a growing and significant phenomenon, with widespread ethical, political, and epistemological implications for the way in which care for displaced populations is imagined and practiced. It remains, however, a largely under-researched phenomenon, whose links with the psychopharmaceutical expansion currently taking place in the Global South have received limited attention. Uganda is a particularly noteworthy case in this sense; here, global mental health pushes for the expansion of (pharmacological) mental health care unfold in the context of the massive influx of refugees into the country, as well as within the country's heavy dependency on external and development funds.

In this chapter, I have argued that the increased influx of psychopharmaceuticals in Ugandan refugee settlements should be understood as the product of a complex psychopharmaceutical nexus, to which several different dimensions have contributed in different ways in recent years. Firstly, I have proposed to trace this phenomenon to clinical, moral, and political changes taking place in the global therapeutic landscape of humanitarian emergencies, and especially to shifting relations between global mental health, development, and humanitarian policy, which have resulted in a strong push towards the integration of mental health within primary health care in refugee and other low-resource settings.

Secondly, I have shown that Uganda proved an ideal candidate for the piloting of supposedly innovative policies in view of the country's attempts at national mental health reforms, and how this history has informed recent developments in the country's refugee policy. I have

argued that the combination of all these factors can represent an (at least partial) explanation for the increase in psychopharmaceutical prescription in refugee settlements, a growing phenomenon both in Uganda and other 'refugee hotspots' in the Global South. I have shown that psychopharmaceuticalization of the Ugandan refugee response is an expression of the growing expansion of psychopharmacology in the Global South. However, global and local dimensions in the study of (psycho)pharmaceuticals are interrelated in ways the go beyond the demonstrative capacity of a case study. Several important contributions to the anthropology of medicines have noted the interconnection of such dimensions.

For example, Van der Geest, Whyte, and Hardon (1996, 2002) have taken a 'biographical approach' to pharmaceuticals, noting the generative potential of studies of medical artifacts from their production to their marketing, to their prescription, and finally to their uses and efficacy. The effects of medications, the authors show, are situated on a scale that far surpasses the impact on individual bodies, symptoms, and moods (Whyte et al. 2002). Ecks builds on this point, suggesting that individual, social, and political effects of pharmaceuticals cannot easily be separated, and should instead be considered together through a research methodology that "follow[s] pharmaceuticals around" (2005:245). As noted by Tran and colleagues (2020), furthermore, people's engagement with pharmaceuticals is both a product of the specific characteristic of a medication, as well as of the socio-political order from which clinical practices emerge.

Finally, I have outlined some of the most prevalent criticisms that the integration of mental health care in low-resource refugee settings has received. These emerging criticisms crucially highlight both the emerging failures and possible detrimental effects of refugee and global mental health policy, as well as the need for experience-near research of refugees' experiences of mental health interventions. In the next chapter, therefore, I return to the empirical material on which this thesis is otherwise based, and offer an ethnographic account of refugees' experiences of mental health treatment in Palabek refugee settlement, showing how extended case studies of people living with various forms of affliction can inform an understanding of *why* engagement with integrated mental health services in refugee settings are low, and how this may relate to the (over-reliance) of the Ugandan refugee response on the prescription psychopharmaceuticals. I analyse the empirical realities of psychopharmaceutical use in Palabek refugee settlement, both in the case of common and severe mental disorders, focusing particularly on refugees' experiences of psychotropic treatment and their frequent non-compliance with medication.

Chapter 7. “Let them eat pills”: side-effects, moral experiments, and the politics of non-compliance with psychiatric medications in Palabek refugee settlement

1. Introduction

This chapter explores South Sudanese refugees’ experiences of psychopharmaceutical treatment in the Ugandan refugee settlement of Palabek, where the lives of most people are overwhelmingly marked by food insecurity, scarcity of basic resources, and widespread anxieties about the future. Among the people whose story I was able to follow, most of them interrupted their psychiatric treatment and disengaged from psychiatric care within the settlement, even if in the majority of cases they recognised that the medication was effective in reducing at least some of the symptoms they experienced.

This is not a problem specific to Palabek settlement; low rates of adherence to psychotropic medication are common across low-income settings in Africa (Ecks 2017), and instances of frequent non-compliance with psychiatric treatment have been observed in several countries including Ghana (Read 2012), Uganda (Kule and Kaggwa 2023), Ethiopia (Teferra et al. 2013), Nigeria (Adeponle et al. 2009), and Mozambique (Fabian et al. 2020). However, few studies centre refugees’ voices and experiences of psychiatric treatment to explore and explain non-compliant and resistant attitudes to medication. Furthermore, despite over 76% of refugees and forced migrants being located in the Global South (UNHCR 2022b), research exploring first-hand experiences of psychiatric treatment has mostly been conducted among resettled refugee populations in high-income countries (see e.g., Sonne et al. 2017; Buhmann et al. 2018).

I show that in Palabek settlement, non-compliance with psychotropic medication is a product of forms of structural violence permeating social (and in particular clinical) relations, and a powerful relational tool that refugees actively employ to reclaim a sense of moral agency and personhood. By questioning ideas of universal efficacy of psychopharmaceutical medications, I discuss non-compliance not as a clinical fact, but rather as a social event

through which wider structures of political marginalization, abjection, and social inequality become visible. My findings are in close conversations with Ursula Read's (2012) seminal study of non-compliance with antipsychotic treatment in Ghana, to date one of the few anthropological studies on the subject conducted in the Global South. However, this chapter's considerations encompass both antipsychotic and antidepressant medications, thus expanding some of Read's more general arguments of psychiatric treatment, other than offering reflections which are specific to the context of Palabek, and perhaps particularly to Acholi refugees.

In particular, I focus on refugees' experiences of the *side-effects* of psychotropic medications as critical in the production of resistance to psychiatric medication. Rather than treating them as 'second-order phenomena', I understand side-effects as a crucial site where the experience of psychopharmaceutical treatment is relationally and intersubjectively negotiated. Crucially, I argue for a new theorising of 'side effects' "as outcomes of the interplay between these compounds and the environments in which they are used" (Davis 2018:9; see also Chua 2018). This chapter puts forward an analysis of refugees' experiences of psychopharmaceutical treatment 'from the margins'; the margins of the state, where refugees' lives unfold; those of opaque policy landscapes that facilitate the introduction of psychopharmaceuticals in refugee settings; and finally, the epistemic margins to which experiences of 'side-effects' are usually relegated in global mental health discussions.

Vignette I. A public performance

On a torrid mid-October day in 2019, a celebration of the yearly World Mental Health Day takes place in the refugee settlement of Palabek, northern Uganda. A sizeable crowd of South Sudanese refugees and refugee leaders, UNHCR and NGOs representatives, and Ugandan governmental officials, is gathered in front of a red brick primary school. Tall speakers stand next to a small group of sturdy and solitary trees in the middle of the large field, towering against the dusty grounds of early dry season. Rows of white chairs have been placed under tarpaulin tents for the comfort of the most distinguished attendees, many of whom now shift uneasily in the boiling heat of the plastic structure. With the help of an intermittently reliable microphone, NGO workers deliver one number-heavy speech after another, both to raise awareness around mental health, as well as an attempt to promote their own programmes to high-ranking officials and potential beneficiaries. Their declamations are populated by

catchy, mantra-like global mental health slogans. Humanitarian workers repeatedly remind the audience that *"We all have mental health, it's the degree that varies"*, stressing that *"Mental illness is an illness like any other"*, and that it *"can be cured just like a physical disease"*. Refugees observe from the edges of the field, chatting amongst themselves, sitting or standing in the shade of trees and of the school, coming and going throughout the day.

A series of dance, musical, and theatrical performances follow the long sequence of speeches. These often include ceremonious praise of the organisations' work, simultaneously showcasing to the audience refugees' allegiance and gratitude, and at the same time revealing the operational aspects which NGOs are most eager to emphasise. The unusual lyrics of the song that brought the day to a close, performed in Acholi by a group of refugees and Ugandan citizens, can be rendered in English as follows:

"*Drinking alcohol can make you mad*
Smoking marijuana can make you mad
Taking cocaine can make you mad;
It is really a bad disease
It means that your head has stopped working.
You have to take medication for that
Following what doctors tell you".

Vignette II. A therapeutic address

A group of around a dozen people is gathered under a mango tree in Palabek settlement, sitting on the ground and on small wooden benches, in occasion of a weekly community-based 'psychosocial intervention'. They are aimed at caregivers of people suffering from mental disorder, to help them cope with their loved ones' struggles and provide them with the tools to support them. As an NGO worker lists what he calls *"signs of overthinking",* the late morning shade shrinks; men squint and wipe the sweat from their foreheads, while women move slightly and uneasily on the mats where they are sitting; those who have scarves use them to cover their heads. The NGO employee, a friendly and engaging Acholi man in his forties, tells his small audience that: *"Overthinking can stop you from doing things. That is why we need medication".*

After this first mention of psychopharmaceuticals, psychotropic medications dominate the rest of the meeting. The NGO worker hands out pills to those who request them, checking the medical booklets they show him to confirm their treatment; he encourages people to come to the Health Centres to get a prescription and to *"tell the community about it"*, and invites caregivers to make sure the patients adhere to the treatment. *"Us who take care of people with mental illness* (two wic)*, we have no support*", laments suddenly an old woman, her head wrapped in a blue scarf. The Block Leader adds: *"Those with mental illness should have a uniform to distinguish them from the others".* The NGO worker disagrees, as that would be very stigmatizing. He also them: *"Stigmatization is not good, because it can force people to stop taking their medication."*

2. Psychopharmaceuticals and non-compliance in Palabek settlement

Since 2018, Ugandan refugee management policies include the integration of mental health within refugee primary health care settings (Chapter 6). As a result of this shift, psychiatric officers and nurses operate regularly in Health Centres II and III in refugee settlements,[53] and run mental health clinic days several times a week attending to dozens of in- and out-patients. The prescription of psychopharmaceuticals constitutes a frequent practice in these settings (see e.g., Ventevogel 2014; Hijazi et al. 2011; Hillel 2023). Indeed, the ethnographic vignettes above that psychopharmaceuticals lead intense 'private' lives (Ecks 2017) in Palabek refugee settlement. These 'private' lives are intensely social, too (Whyte et al. 2002), unfolding in different spaces, ranging from public performances which advocate for psychopharmaceutical use, to more bounded discussions taking places during frequently delivered community interventions.

In both cases, however, psychopharmaceuticals occupy significant space. If in the first vignette they emerge as one of the main features of the local refugee response, the second one shows that 'psychosocial interventions' constitute a training, for caregivers and patients alike, in the management of symptoms and bodies, where the role of psychiatric medication surpasses that of any other form of support and where the social capital of the patient

[53] Mirroring the Ugandan health system, facilities in the country's refugee settlements follow a hierarchy which reflects the specialization of the services available at each level – starting from Village Health Teams at the village level, through Health Centres II, III and IV at parish, sub-county and county level, up to Referral Hospitals, which usually serve whole districts (Ministry of Health Uganda 2018).

becomes not so much a source of support as an extension of the psychiatric system. Discourses around medication and compliance were particularly intense around the settlement's Health Centres, the epicentres of psychopharmacology in Palabek settlement, as under Uganda's current refugee policy mental health and psychosocial interventions include the provision of psychiatric care in refugee settlements across the country (UNHCR 2019).

In all these settings – public and private, didactical, and therapeutic – mentions of the availability and prescription of psychiatric medication are inextricably linked to the notion of compliance with treatment, and thus deeply embedded with frames of adherence and discipline which are established within hierarchical power relationships. The emphasis on adherence to treatment in these political and therapeutic contexts was not arbitrary; rather, it stemmed from extremely low rates of adherence to psychiatric treatment among refugees in Palabek. Despite the wide availability of psychotropic medication, the reality of psychopharmacological treatment in Palabek is far from successful; non-compliance with psychiatric treatment is overwhelmingly common in the settlement, particularly in the case of frequently prescribed antidepressant and antipsychotic medications.

Mental health professionals operating within Palabek refugee settlement were keenly aware of the non-compliance issue among their patients, as well as of its potentially dangerous implications; non-compliance to psychiatric treatment involves a number of significant risks for users, including a substantial worsening of symptoms, lower efficacy of following courses of treatment, and increased suicidal tendencies (Farooq et al. 2014). In addition, refugees' discontinuation of treatment often signals their withdrawal from psychiatric care in the settlement. As one psychiatric nurse explained to me:

> *"You will often find that patients don't finish their treatment. Most of the times, they interrupt it [...] and fail to come back to the clinic and renew it. It is a big problem for us"*.

The views of mental health workers differed on many aspects of their practice, ranging from the causes of refugees' mental distress to the best approach to tackle it; however, they seemed to agree on the root causes of non-compliance with psychopharmaceutical treatment. Lack of adherence to medication, they explained, resulted from a combination of a worsening of psychiatric symptoms (*"When they stop complying, you will find that they are already relapsing"*, one mental health worker explained to me); poor mental health awareness; and traditional cultural beliefs.

Psychoeducation sessions were generally identified as the main solution to these challenges, to educate patients on the 'right' kind of mental health knowledge in order to discourage them from pursuing different healing pathways, as well as ensure compliance with the treatment. *"When this* [non-compliance] *happens, we need to give them psychoeducation, to educate them and tell them it's good to take medication"*, a psychiatric nurse explained. Instructions on how to appropriately take medications were repeated during most clinical visits, several times a day, every time the clinical staff suspected that the compliance with the treatment had been in some way compromised. Community interventions such as the one described in Vignette II were used as opportunities for psychoeducation, too, as an NGO worker explained: *"Most of them* [the patients] *don't adhere to treatment, and yet it's the treatment which is bringing some healing in them; in these psychosocial interventions we talk about compliance a lot. It's the key thing"*.

Psychoeducation sessions strongly framed 'cultural beliefs' as obstacles to psychiatric practice and biomedical treatment; mental health professionals in Palabek often lamented that many of their patients seemed to withdraw from mental health services in favour of traditional healers and spirit mediums. The nurse's speech addressed these issues as well: *"In the past, people used to say that it was* cen *disturbing the person, or the* jok". [54] The temporality employed in the speech upon mentioning these spiritual afflictions conveyed an important message: traditional beliefs were a thing of the past, while medical care was equated with ideas of development and progress:

> "*When someone is running from something they cannot see, the community will say they are affected by* jok. *But when you see someone like that, you need to tell them to go to the hospital. Here we give medicine for such people and we also give training on mental illness. So, if you have one of these problems already, and you are here right now, come see me today."*

In ascribing the causes of resistance to medication to psychiatric deterioration, lack of mental health awareness, and 'cultural beliefs', the views of mental health professionals in Palabek were in line with the ways in which the issue is commonly framed in the literature. As Read notes (2012), clinical studies generally explain non-compliance with psychopharmaceuticals as motivated by individual traits and clinical characteristics, such as patients' lack of insight or psychiatric relapses (see e.g., Semaghen et al. 2020; Mert et al. 2015). When non-

[54] For a more detailed discussion of these notions, see Chapter 1 of this thesis.

compliance occurs among populations originating from, or being treated in, the Global South, cultural barriers such as poor mental health literacy, lack of appropriate cultural translation, or local cosmological ideas about the cause of mental illness tend to be mobilised to explain resistance to psychiatric medication (see e.g., Ostuzzi et al. 2017; Ibrahim et al. 2015). Often, non-compliance with medication is framed as "antithetical to progress and advancement", and resistant patients as "backward, uneducated, and irresponsible" (Jain and Jadhav 2009:71).

Medical anthropologists have long tried to complicate this picture, noting that ideas of medical 'efficacy' are not fixed, but locally defined (Etkin 1992; Biehl 2004) and that (non)compliance is a complex phenomenon, shaped by the interaction of culturally relevant imaginaries of health and the nature of therapeutic relationships (Read 2012; Petryna et al. 2006; Kirmayer and Raikhel 2009). The 'total' effect of medications is inevitably shaped by social and ecological factors, while medications' effects are not relegated to their clinical and chemical impact on bodies, but rather that they inevitably affect social relations (Whyte et al. 2002; Jenkins and Kozelka 2017; Whyte and Meinert 2006).

However, people's subjective experiences of psychotropic medication in low-income settings have rarely been investigated, signalling that the 'experience gap' in global mental health (Kohrt and Jallah 2016; see Chapter 1) extends to the phenomenology of psychopharmaceuticals, too. Partly, this is due to the fact that anthropological perspectives have been often side-lined in the name of bridging the 'treatment gap' in global mental health (Lovell et al. 2019; Jain and Orr 2016). Furthermore, anthropological critiques of psychopharmaceuticals in global mental health interventions have mostly emphasized potential risks of medicalization in 'scaling-up' psychiatric treatment, and argued that the imposition of psychotropic medication might disregard locally significant forms of healing in non-Western contexts (e.g., Mills and Fernando 2014; Summerfield 2012; Bracken et al. 2016), rarely questioning what follows the prescription and ingestion of psychiatric treatment – its effects, efficacy, and limitations.

In what follows, I introduce Justin's story, which illustrates how experiences of mental illness and psychopharmaceutical treatment in Palabek unfolded at the intersection of 'extraordinary conditions' (Jenkins 2015) of affliction, displacement, and of dependence on the ambivalent humanitarian landscape of the settlement. These experiences emerge as fundamental in

shaping people's moral worlds, and deeply reverberate on Justin's and many others' experiences of psychiatric medication in Palabek refugee settlement.

3. A case of 'non-compliance'

Justin's madness is back. It is late May 2019 when Aloyo, Justin's mother, calls us to tell us that, the previous night, Justin has burnt down his mud hut and run away in the bush. The nearby residents in the settlement are scared and disturbed by his behaviour. This is not the first time Justin has set fire to his and his mother's belongings, and fears of destruction of property are particularly acute in this remote area of settlement, where humanitarian workers rarely venture, and the scarcity of basic resources is sharpened by the absence of both state and non-governmental institutions. Over the phone, frantic with worry, Aloyo tells me and Samuel that she doubts Justin will return soon, as he knows their neighbours may hurt him if he does. However, when we visit Aloyo's home the following morning, Justin is indeed back and sitting quietly on his feet at the edge of the compound, looking at the ground. He has grown very thin since the last time I saw him, just the previous week. His black jeans, which he usually treats with great care, are torn and kept up with a fine piece of rope, and his blue t-shirt is worn out. We sit together in the empty compound for a while. Justin draws in the dust with a small stick; his feet and arms are full of scratches from being in the bush. Speaking softly in his fluent English, Justin tells me that he has been confused again lately, and that he has stopped taking the antipsychotic medication that he has been prescribed at the Palabek settlement's mental health clinic.

I had first met Justin, an Acholi-speaking refugee in his mid-twenties, in March 2019, in the waiting room of the Health Centre III, the biggest of the settlement. When I asked why he was there, Justin answered right away, eager to talk: *"I am just here to ask for my cards back. I am not sick; I just have some mental problem."* I later learnt that the reason why Justin visited the Health Centre that morning was to try and obtain a copy of his refugee identity card and ration card. Essential to his sustenance in Palabek settlement, both documents had gone missing during his recent hospitalization in Kampala's Butabika National Referral Mental Health Hospital, the only mental health hospital in Uganda. He had been transferred there by the NGO which managed the Health Centres in the settlement, following a particularly violent episode in late 2018. Justin's experience at Butabika had been one of

abuse and neglect; other patients had stolen the little money he had with him, while he felt that doctors were not paying much attention to him, as he was a refugee and alone in Kampala. He had soon escaped from the hospital and somehow, still experiencing severe symptoms and with no money for food or transportation, had found his way back to the settlement. Meanwhile, interviews with the doctors in charge of his case in Palabek settlement reveal that no one among the of the NGO workers or UNHCR staff had ever looked for him, despite being aware that he had disappeared from the facility.[55]

Following our encounter at the Health Centre, I visited Justin often at his mother's place where he stayed, he said, because he was not well enough to live by himself. Justin's sickness started in late 2013; following a second episode in 2015, he joined a church and felt better for a while. Since he fled South Sudan in 2017, however, things have gotten worse: *"Here in Uganda, the sickness came twice. Two times. I don't understand, it is too much"*, he told me when we first met, just before the relapse which led me to his compound in May 2019. His biomedical diagnosis is uncertain; he received his first psychiatric assessment in Palabek in 2018, where he was diagnosed with bipolar affective disorder – although some doctors replaced this label with the somewhat vaguer one of 'psychosis'. During his episodes, Justin is often destructive and euphoric, and experiences grandeur delusions and multisensory hallucinations.

The diagnosis of bipolar disorder is not the only explanation available. Justin's relatives are convinced that he was bewitched by a jealous work colleague during his time in Juba, where he had moved in 2011 to look for a job as a schoolteacher; however, he had different explanations for his *"mental problem"*. Justin thinks that his sickness was initially caused by witnessing atrocities in Juba when the civil war began; however, these days things are different. As he articulates it, his sickness today has much more to do with worries about his present condition as a refugee, to the hardship of life in Palabek refugee settlement, and to worries connected to the impossibility to work and earn an income and the difficulty of getting married in such condition:

> *"I'm sometimes very aggressive to people. Is it maybe the result of too much annoyance? If I was in South Sudan, I would have easily gotten a job… Now here I*

[55] While this signals gross negligence on the part of both institutions, which granted no protection to Justin, it should be noted that escapes from Butabika hospital are very common (see e.g., Pringle 2019).

am, not getting jobs. That may result in the aggressiveness, that is why I am fighting people".

When he tried to apply for a job that fit his qualifications as a schoolteacher, NGOs rejected him: *"For us who are teachers, when we came, our papers were not valued. They just said, 'this paper is for South Sudan', so they gave the jobs to the nationals here".* He did not have much luck finding other kinds of work, either; like many residents of Palabek settlement, he encountered frequent hostility from the host communities (see Chapter 2), who were concerned about refugees' presence and use of natural resources in the area. "*I can do any job […] but here they don't give jobs to refugees; they don't consider them much. You may inquire about jobs, you will move around but you will not get anything"*, he explained.

He often spoke of going back to Pajok to look for work or money, like many people – and particularly young men – were doing at the time: "*I hear people nowadays have started going back to farm. Maybe I should also do that, and at least work on my land".* He wrestled with that thought; while he felt like this may be his only option, he feared the ongoing insecurity in South Sudan:

> "*When Juba was being destroyed by these people, I was there. I have seen some of the people that were killed, their blood, how they were tortured, how they were massacred. Sometimes I just remember those things. We have no defence there."*

In 2018, following his diagnosis of bipolar disorder, Justin had been prescribed the antipsychotic chlorpromazine (CPZ) at the mental health clinic in Palabek settlement. He was adamant that the pills helped him significantly with his *"mental problem"*. His relatives confirmed this: *"When he is taking them, he likes to stay with people. He's always telling funny stories"* Aloyo and Grace, Justin's sister, explained. Despite the benefits he reported from the medication, he repeatedly chose to stop taking it.

All of Justin's sickness episodes that I witnessed during my time in Palabek followed a similar trajectory; after complying with the treatment for a while, he would abruptly interrupt it, to which a relapse ensued. Due to his mother's and neighbours' concern for his and their own safety, Justin would then be hospitalised, sometimes for weeks at a time, at Palabek Health Centre III. There he would be sedated, given heavy doses of CPZ treatment and sent home, where it would not be long before the same cycle of events repeated itself. Between May 2019 and March 2020, this would occur at least an additional four times; Justin's relapses would get more acute, and his recovery more uncertain every time. Whenever he

became unwell again, he often could not fully open his eyes; his speech, usually clear and coherent, became slurred and unintelligible. Even at the peak of his illness, however, the one thing he was able to clearly articulate – both in English and in Acholi – was that he needed to go back to South Sudan.

4. Findings

Justin's story, as disturbing as it is, is far from unique in Palabek refugee settlement. Many of my interlocutors, particularly those whose treatment consisted of antipsychotic or antidepressant medication, chose at various points to interrupt it – even if most of them openly reported that they found relief in the short-term benefits of the medication. Like Justin, several of my interlocutors subsequently entered cycles of violent psychiatric relapses and increased hopelessness about their condition.

Reasons for non-compliance varied and people often cited more than one. Some reported experiencing no effects from the medication. Others had interrupted the treatment following instances in which their medication was unavailable at the Health Centres; they would have had to buy it themselves at a local pharmacy but could not afford it. Still others cited being away from the settlement when their prescription ended (often, they had travelled to South Sudan or other parts of Uganda to work, visit relatives, or attend weddings or funerals). In their ethnography of a community psychiatric clinic in India, Jain and Jadhav describe similar clashes between the 'social calendars' on which clinicians and patients operate – the former dominated by the biomedical temporality of treatment regimens, the latter by immediate needs and by a range of obligations of local social and moral worlds (2009:67). While this point holds in Palabek too, and I did find that the biomedical temporality of treatment regimens was often challenged by the patients' schedule, in this chapter I focus on a different – and more prevalent – reason that frequently led to interruption of psychiatric treatment among my interlocutors in Palabek refugee settlement.

The most common reason why my interlocutors in Palabek settlement interrupted their treatment had to do with the medications' side-effects, and with their widespread consequences for refugees' lives. The attribution of meaning to side-effects (and, by extension, to the psychiatric treatment) is a process unfolding through relational exchanges, which, though organic by nature, is perhaps best analytically examined as negotiated across

three different relational dimensions. Firstly, side-effects' encounter with the socio-economic circumstances of refugees' displacement; secondly, their significance in relation to refugees' perceptions of health and of their own moral personhoods; and finally, their role in the context of refugees' fraught relationship with the humanitarian apparatus in Palabek settlement.

4.1. Side-effects as products of food insecurity

Talking about the reasons why he had decided to stop taking his medication, Justin explained to me: *"Those tablets, they require so much food. I have been working in the garden these days, but I have to eat from morning up to 1pm if I take them".* Justin is right; CPZ, the most commonly prescribed antipsychotic in the settlement, requires users to increase their daily food and water intake to physically sustain treatment and maintain a degree of social functioning in their daily lives.

Often described as having kickstarted the 'psychopharmacological revolution' in modern psychiatry (Rosenbloom 2002), CPZ was frequently hailed in clinical literature and practice as a 'miracle drug'. However, it has multiple and significant side-effects (Chokhawala and Stevens 2022), including what is often described as 'considerable weight gain' (Bernstein 1988). This assessment, however, requires clarification. CPZ does not cause 'weight gain' per se; rather, it is known to cause low blood pressure, dizziness, and – especially – a notable increase in appetite (Mayaan and Correll 2010). This distinction is relevant; framing 'weight gain' as a side-effect is an incorrect assumption, embedded in bias rooted in the socio-economic characteristics of the environment in which CPZ first emerged. Side-effects such as low blood pressure and increased appetite can indeed lead to weight gain – but this causal relationship can only be taken for granted in food-secure environments such as those in which CPZ was first produced, tested, and distributed (namely, controlled clinical environments across the Global North, such as asylums and later, when deinstitutionalisation processes took place, closely supervised therapeutic relationships).[56] In her ethnography of a psychiatric

[56] Here I do not mean to suggest that food insecurity only occurs in the Global South. As a multitude of studies of chronic poverty in rich nations suggests, food insecurity certainly exists among poor communities across the Global North (Penne and Goedemé 2021), and is indeed considered a growing phenomenon, particularly in the aftermath of the 2008 recession (Davis and Geiger 2017) and, more recently, in the wake of the Covid-19 pandemic (Toffolutti et al. 2020). However, food insecurity and poverty do not always overlap (Cook and Frank 2008); while individuals and households experiencing poverty in high-income countries do not necessarily experience food insecurity, the opposite is often true for people living in low- and middle-income countries,

clinic in North America, Jenkins describes her interlocutors' experiences with psychopharmacological treatment as being characterised by a paradoxical choice between being 'crazy' or 'fat' (2015:66). In a context in which CPZ treatment cannot be easily accompanied by an increase in food consumption, its prescription can often lead to an exacerbation of feelings of hunger, as well as of other side-effects such as dizziness and sedation (Adams et al. 2014).

The first-generation antidepressant amitriptyline (AM), the most commonly prescribed of its kind in Palabek refugee settlement, posed the same issues. It is widely acknowledged that most psychotropic medications cause require increased food intake and cause acute forms of dizziness and fatigue; however, these effects are particularly prominent in the specific cases of CPZ and AM (Bernstein 1988). Research conducted since the 1970s shows that CPZ causes the highest appetite scores of any antipsychotic medication (Robinson et al. 1975; Dayabandaraa et al. 2017). AM's effects on appetite increase have also been widely documented; a comparative study observed that AM caused the greatest increase in appetite among four antidepressants (Fernstrom and Kupfer 1988).[57]

Side-effects related to hunger pose significant challenges to refugees in Palabek and are anything but simple medical facts. In this context, psychiatric treatment places additional and significant burdens on already severely resource-strained and food-insecure families, causing severe tensions. Justin's mother was deeply aware of the issue: *"When he is taking those tablets, he will ask for a lot of food, which is not easy"*, Aloyo admitted with a burdened look on her face one time I went to see her, while Justin was hospitalised. She had never remarried after the sudden death of Justin's father in the early 1990s and was alone supporting herself and her children. With the help of one of her brothers, she was able to send two of Justin's younger siblings to a secondary school in South Sudan, and most of her few financial resources went towards their education. Being able to afford more food for Justin to sustain treatment was not an option. When she had tried to grow vegetables and cassava on the plot

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where poor households are significantly more likely to be food insecure (FAO 2022). The difference in prevalence of food insecurity is extremely stark; for example, while countries in the European Union averaged 1.6% of households experiencing severe food insecurity in 2020 (World Bank n.d.), recent studies estimate severe food insecurity affecting 9% of households in Uganda and a staggering 64% of refugees in the country (World Bank 2021). The relationship between food insecurity and low adherence to psychotropic medication is thus more frequently observed in low-resource settings across the Global South, where severe food insecurity is more often found.

[57] These effects are so well-known that in the mid-1980s trials were conducted to explore the potential of the medication to treat severe eating disorders such as bulimia nervosa and anorexia nervosa (Davis and Attia 2017; Biederman et al. 1985).

of land she had been allocated, like many refugees in Palabek she had found that nothing the family could eat or sell could be grown there (see Chapter 2). Her plot sat in the middle of one of the swampiest areas of the settlement, and immediately flooded at the first rain of wet season; the first time Samuel and I visited Aloyo's home, we sank up to our ankles in mud and water. Justin had found a small area in the bush nearby to clear up, where he hoped to plant greens for him and his mother; but hunger and dizziness induced by his treatment made it difficult for him to work.

Albert, a Kakwa-speaking South Sudanese refugee, had a similar story. I spoke to him at his home, while he lay down on his side to soothe his back pain; to earn a small income, he broke and sold stones, transporting them to his home from the riverbank several times a day. He had been prescribed CPZ in Palabek for his psychotic symptoms and was well-known to the settlement's mental health workers for his continuous relapses. He recounted that when he took the medication he felt better; the voices he sometimes heard were quiet, and he managed to sleep through the night. [58] Yet, he explained:

> *"If I want to work late, I will skip it. It makes me too hungry, and it makes me sleep too much. If I sleep too much, where can I get soap? The UN is not giving soap. And it's not like you can always eat beans. You need to change diet".* [59]

Issues around food scarcity and treatment adherence, while especially relevant now with the growing expansion of psychopharmaceuticals in refugee settings across the Global South, are not new. While discussions around psychotropic medications' use and treatment sustainability in food-insecure environments are largely absent from the literature, similar issues have been observed in other resource poor contexts in Africa. For example, both Ursula Read (2012)'s work on antipsychotics in rural Ghana, and Teferra and colleagues' (2013) research on psychosis treatment in Ethiopia point out that food-related side-effects heavily contributed to their interlocutors' non-compliance with treatment. The dilemmas

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[58] Albert attributed the voices he heard to a spiritual force that he had disturbed while moving stones by the riverbank.

[59] Unlike the other cases in this chapter, all of whom I was able to follow for extended periods of time, I was only able to speak with Albert once (although for several hours). Samuel and I went back many times to look for him and follow up on his story, but always found his home empty, and the grass thatched huts in his compound secured with locks and chains. Eventually, the Block Leader informed us that Albert and his family had returned to South Sudan but offered no further explanation. While I am not aware of his reasons for doing so, based on our only conversation they may be related to ethnically motivated intimidation that Albert and his family received from their Langi and Acholi neighbours; Albert had also mentioned wanting to go back to farm on his land.

created by food-related side-effects of psychopharmaceuticals foreground once again issues that have emerged in the context of other kinds of treatments which have played significant roles in public health responses, and particularly in Uganda. Food insecurity is known to affect adherence to tuberculosis treatment (Baldwin et al. 2004). Parker and Allen (2011), on the other hand, have observed that treatment for neglected tropical diseases was severely impacted by local political and economic dynamics – and especially conflict outbursts – affecting food supply. They noted frequent refusal of communities to swallow the medication (praziquantel for the treatment of schistosomiasis, and albendazole for soil transmitted helminths) in the absence of sufficient food to mitigate the side-effects, and showed that adherence rates to treatment fell sharply when WFP could not operate in the area.

The issue of non-adherence related to hunger and food scarcity is especially reminiscent of problems noted by the wide literature exploring the effectiveness of the HIV response, where the relationship between food insecurity and poor adherence to anti-retroviral therapy (ART) has frequently been observed. Young and colleagues' (2014) comprehensive review of adherence to ARTs in resource-poor settings across Sub-Saharan Africa and South America found that often patients interrupted treatment since ART significantly exacerbated hunger. Olupot-Olupot and colleagues (2008) and Wilhelm-Solomon (2011) have noted this relationship in conflict-ridden northern Uganda; like Whyte and colleagues (2006), they emphasise the role of mutual support, and of additional food assistance in ensuring adherence to treatment – vital in ensuring the medication efficacy.

Such support, however, is not always possible in Palabek, given the extent to which resources are already stretched for most refugees. Borrowing food or money often leads to cycles of debt that become increasingly hard to break (Chapter 4); it is not surprising that Palabek is the Ugandan settlement with the highest rate of refugee households with debts to repay, with over a third of respondents reporting being in debt (34%). In over a half of cases (55.1%), the reason for going into financial debt was to buy food (Government of Uganda et al. 2018). These figures paint a picture of Palabek settlement as a context in which economic self-reliance is a distant possibility for most refugees and in which every day survival requires eroding existing resources, when present, to supplement inadequate humanitarian assistance.

The magnitude of the impact of food-related side-effects emerges through medications' encounter with the social, economic, and political context in which they are introduced. In Palabek settlement, this entails medications' interaction with states of widespread food

insecurity, chronic poverty, and unemployment. Similarly to the "painful priorities" described by Whyte and colleagues (2006:249), which patients and their families need to establish in the face of the financial burden of HIV treatment in Uganda, psychopharmaceuticals force patients and their families to confront an impossible dilemma. As most people are unable to purchase more food to complement the inadequate emergency assistance, family members must go hungry, or rely on forms of mutual material support (such as borrowing food from neighbours or relatives), to allow for treatment to be sustained by those taking it.[60] If this cannot be done, patients' ability to work and earn small amounts of money will be significantly impaired – as will be their basic functioning, given the severity of the medications' side-effects. Simply put, if the dilemma faced by Jenkins' (2015) interlocutors is between 'crazy' and 'fat', in Palabek, the choice with which refugees are confronted with regards to psychopharmaceuticals, is a binary of 'crazy' or 'hungry'. If treatment is interrupted, there is a high likelihood of relapse; patients and their families were keenly aware of the recurring temporalities of their afflictions.

"With this sickness here, we know it will come back", Justin's uncle Ojara plainly explained to Samuel and me. When in early 2020 it became obvious to his family and doctors that Justin could no longer stay at his mother's home, Ojara agreed to take him in. Justin's food needs and violent outbursts whenever his sickness came back had become overwhelming for Aloyo, who had had to rebuild her home several times after Justin set it on fire. Justin's younger sister Grace played a vital role in persuading Aloyo to let Justin move to Ojara's home: *"It will be better"*, she said, *"because we cannot always make sure that he is taking his medication"*. Furthermore, she explained, Ojara lived right next to the Health Centre, and was doing slightly better financially; he was renting a small piece of land from a Ugandan citizen he had befriended and was able to make charcoal there which he sold from time to time, earning a small income. At least at Ojara's home, food was not as much of a problem. Aloyo was heartbroken (*"A mother needs to always be with her son"*, she told me with a sad smile), but in the end agreed that it was for the best.

[60] It should be noted that these figures are likely to have increased since the severe food cuts of June 2020 and the socio-economic hardship caused by the lockdowns related to the Covid-19 pandemic. At the time of writing, however, the survey is yet to be updated.

4.2. Side-effects as threats to moral personhood

The few work opportunities in Palabek caused Justin deep worries for both economic and social reasons, relating especially to the possibility of getting married, starting his own family, and being able to adhere to Acholi social, moral, and gender roles. This would be impossible without being able to earn an income, either by finding some form of employment or land to cultivate. Betraying his worry that he would not be able to find either of them anytime soon, he explained:

> *"If you are to have your own family, like a wife, the children… life is hard if you have to stay like this. My plan is that until the peace resumes in South Sudan, I may stay single just like that, for life."*

For Justin, complying with the CPZ treatment meant therefore giving up on the little work he could carry out in his small garden, which was essential both to try and improve his and his family's present circumstances and to adequately perform as a young Acholi man. As concerns about side-effects spoke directly to the possibility to work, and to perform culturally relevant social and gender roles, increased hunger, dizziness, and fatigue as a result of psychopharmacological treatment exacerbated already significant worries that my interlocutors often voiced.

Even when side-effects of medications did not lead to non-compliance, they often impaired social functioning to the point of completely trumping a sense of efficacy of the drug. This was the experience of Irene, a middle-aged Acholi-speaking woman refugee who had been prescribed psychiatric treatment at the Palabek mental health clinic. Irene was remarkably resourceful, but her life was not easy. Both her son and daughter-in-law had been killed by government soldiers in South Sudan: *"It's an unhappiness that does not end"* she said, describing the grief that often overwhelmed her. She took care of four of their six orphaned children by herself (two lived with her brother in Juba) and had fled to Uganda hoping that they could access the free education provided to refugees in the settlements; in Torit, where she lived in South Sudan, all schools had been closed due to the war. She manifestly adored her grandchildren; taking care of them in the context of Palabek settlement, however, exposed her to hardship and extreme anxieties.

The first time she was referred to the mental health clinic, she had gone to the hospital lamenting severe trouble sleeping and a pain in her chest. The pain had started, she explained, from when she heard about the death of her son; it had aggressively come back recently,

when she received news that her uncle, too, had been shot and killed by soldiers in Juba. To the mental health worker who gently questioned her at the clinic, she told how she had spent all her savings on medical care for her youngest granddaughter who had been severely ill; the settlement did not have the right medication, and Irene had to take her to Kitgum. Because of this expensive and unforeseen crisis, she had not been able to resupply her foodstuff stall, on which she had been relying for a small but relatively stable income. The anxiety in her voice was palpable. Two of her grandchildren had recently been turned away from school because they did not have uniforms or books, which she simply could not afford.

When Samuel and I visited her in the privacy of her own home, where she did not fear the judgement of humanitarian workers, she explained that she felt out of options: *"I am just waiting for food distribution, so I can sell it and give the school the money"*. She also elaborated on the ways in which the chest pains made her overthink:

> *"The pain reminds me that no one here is helping me. It's spoiling my head […] It's all about the thoughts. If I start thinking about who can help me, then evil spirits* [cen] *come to me at night. They come as the parents of the children; they stand and talk to me. They see that no one is helping me, and they say that if I cannot afford to take care of these children, it is better that they* [the spirits] *to take them'."*

At the mental health clinic, she was diagnosed with post-traumatic stress disorder (PTSD) and prescribed AM.[61] She had taken the pills for the twelve days her prescription lasted, meticulously following the doctors' indications.[62] The medication did make her sleep, thus effectively reducing her insomnia. However, she explained:

> *"It made me become very drunk. When sitting or lying down, I would find that everything was spinning; when I stood up, I fell down. It was difficult to stay with people. […] I could not work at all. Cooking for my children was not easy, and also doing housework".*

Despite the suffering her insomnia and somatic symptoms caused her, the dizziness and lingering sedative effects of AM imposed rhythms that were not sustainable in the context the heavy pressure she felt to care for her home in Palabek; rather, they compounded her fears

[61] Amitriptyline and other antidepressants are frequently prescribed to treat PTSD, though usually in combination with psychotherapy (Akiki and Abdallah 2019).
[62] Amitriptyline can be effective within two weeks; it was common for treatment to be prescribed for short periods of time due to limited availability of medications at the settlement's Health Centres.

that she may not be able to care for her grandchildren, while also keeping her from participating in community life. When she went back to the Health Centre, her prescription was not renewed.[63]

South Sudanese refugees' choices around compliance with medication, and the meanings attributed to the medication side-effects, emerge as closely related to the possibility of social functioning. Here, my findings closely mirror Read's (2012), whose work demonstrates that experiences of psychiatric treatment, and particularly those of the medications' side-effects, were profoundly shaped by local conceptions of health and socio-economic needs; her interlocutors also lamented not being able to work or to adequately perform their social and gender roles while on treatment. The role of local and culturally relevant notions of health has often been noted in global health and medical anthropological literature as a crucial factor influencing illness trajectories and engagement with treatment. Read's observation that in Ghana "health is allied with strength, and healing is signified by a return to productivity" (2012:447) widely applies to Acholi, as well as to other language groups in Palabek settlement.

The prioritisation of social functioning over symptom reduction is certainly worth noting in order to take seriously refugees' understandings and choices in regard to psychopharmaceutical treatment. Among South Sudanese refugees, as well as large parts of societies across the African continent, conceptions of health are closely related to the ability to participate as members of community, provide income, and fulfil gender and societal roles. As side-effects narrow refugees' possibility of fulfilment of social roles, psychopharmaceuticals cannot be perceived to restore health. Here I wish to expand on this consideration, to show that compliance with treatment among refugees in Palabek has as much to do with ideas of health as it does with moral and ethical notions of personhood, where the former are rooted in the latter.

To better understand the existential and phenomenological implications of medications' side-effects on refugees' lives, I draw on the notion of 'moral personhood' (Chapter 2). As described by P'Bitek (1986) and O'Byrne (2016), a 'good existence' is achieved through publicly performed pragmatic activities, such as having good manners ('kite ber'). Significant emphasis is put on one's ability to prove oneself 'hardworking' ('latic ma tek'), ranging from

[63] I was not able to determine if the doctors' decision to interrupt Irene's treatment was due to her response to it, or to whether she was not deemed to need it anymore.

the ability to cook tasty food to the demonstration of enthusiasm for (and endurance of) physical work, in a measure adequate to prove oneself a ’good’ person – an attentive parent, a caring spouse, or a prospective partner whose eagerness to look for and perform work can be interpreted as the mark of a hopeful future. This is a powerful form of “dialogic social action” (O’Byrne 2016:59) through which moral personhood is constituted.

An existential orientation of ‘lived pragmatism’ (O’Byrne 2016) implies that these activities are essential in establishing one’s moral and social value, as “actions and statuses […] are not considered achieved until they are ‘seen’ by others”, indicating an “everyday epistemology that relies on making things known by making them visible” (Piot 1999:101 in O’Byrne 2016:86). Not being willing or able to perform such activities and roles has grave social, moral, and existential consequences. In p’Bitek’s words, someone without manners (‘la kite pe’) “is a nothing. […] Yes, all the biologicals are there, but not the social. […] Often such a fellow is described as pe dano, not human” (1986:27). Similarly, the inability to demonstrate being ‘latic ma tek’ puts a socially validated sense of ‘moral personhood’ dangerously at risk, evoking possibilities of ‘social death’.

This becomes particularly relevant in displacement, where deep and widespread ruptures to social and moral order deeply complicate and often jeopardise refugees’ ability of performing, and thus achieving, moral personhood. This carries important implications for dealing with mental illness in the everyday, including for compliance with psychiatric medication. In a rare commentary on psychopharmaceuticals efficacy in resource-poor setting, Jenkins and Kozelka argue that: “When these drugs produce side-effects that further decrease the person’s ability to participate in society, it is understandable why patients and their families would decide that the best decision would be to stop taking them” (2017:161). If communal and individual sense of morality and ‘social harmony’ (Porter 2016) is jeopardised under the extraordinary conditions of displacement, side-effects of psychiatric treatment further diminish opportunities for pragmatic actions oriented to the preservation of a moral structure of life. Thus, psychopharmaceuticals emerge as unable to be perceived to restore health, but also as offering “only control [on symptoms] but not social healing” (Mhina 2009:152; Read 2012). In the ‘fundamental human process’ (Jenkins 2015) of striving for an ethical life, adherence to treatment emerges not just as a therapeutic, but also as an economically and – crucially – morally connotated project.

4.3. Side-effects as embodied abandonment

The meaning and relevance of side-effects of psychiatric treatment are produced by the interaction between the medication and the socio-economic and political environment in which it is introduced. Understanding refugees' suffering as a struggle to maintain a sense of moral personhood within the structural constraints of displacement allows us to understand side-effects as embodied manifestations both of the structural injustices of life in Palabek, and of threats to the social and moral order of refugees' lifeworlds. The disruptive impact of dizziness, hunger, sleepiness, and other uncomfortable effects of psychiatric drugs is not inevitable, but rather exacerbated by inadequate assistance and a general political abandonment of refugees. In this context, humanitarian workers' attitudes cause side-effects to take on a third symbolic meaning, this time related to refugees' relationships with the wider humanitarian apparatus in Palabek.

Humanitarian workers were acutely aware of the interaction of side-effects with the food-insecure context of Palabek refugee settlement, as well as of the other ways in which food insecurity and chronic poverty were impacting their patients' health – both physical and psychological. Yet, these issues were never explicitly voiced in clinical encounters, and humanitarian workers never openly addressed them. Rather, mental health workers continuously included food-related recommendations during their psychoeducation sessions on compliance: *"When you take this medication, you need to make sure to eat a lot of food, and to drink water"*, a mental health nurse repeated to his patients during individual clinical interviews. *"You should not be idle; you should get some land and do something"* was another common advice delivered in the consultation room. While well-meaning, these instructions ignored the structural challenges to their fulfilment. Throughout my fieldwork, I never observed or heard of patients challenging the doctor on these indications; nor did I witness any instance in which health workers openly acknowledged the ways in which life in displacement posed obstacles to following these recommendations. Clinical consultations remained depoliticised settings, where the elephant in the room of the failure of the emergency response could be felt in patients' silences while doctors offered advice, medication prescriptions, and compliance recommendations.

Humanitarian workers' disengagement with refugees' socio-economic realities did not stem from lack of care or empathy; rather, feelings of helplessness among humanitarian workers

were frequent. With a heaviness in his voice, one mental health worker told me how much his job burdened him:

> *"You know, sometimes it's very hard, you feel like you are handcuffed…you have this person in front of you, he has so many needs, what can you do? The best I can do is to give them the medication, so at least they can sleep at night."*

However, it is worth considering politically connotated reasons underlying the lack of mention of the failures of the refugee response in these settings.[64] Humanitarian workers' avoidance of structural considerations can be understood as manifestations of what Tapscott has described as the Ugandan state's 'institutional arbitrariness', which "makes it difficult for citizens and local authorities to calculate and assess the risks of possible intervention" (2021:3), creating "an environment of suspicion and fear that causes people to self-police" (ibid:67).

Commenting on psychosocial interventions' focus on compliance with treatment, one NGO worker explained to me: *"Caregivers complain that their relatives need more food* [when on treatment]*, and yet what they get from UN is already too little".* She made this statement in a whisper, worried that she may be overheard. There was a seemingly paradoxical element to her tone; while her caution would have fit a topic shrouded in secrecy, the profound inadequacy of food assistance is an incontestable reality of the Ugandan refugee response. It is an issue constantly and vocally denounced by refugees in Palabek (e.g., O'Byrne 2021; see Chapter 2), and international policy documents decrying the underfunded nature of the emergency openly address it (see e.g., World Bank 2021; Mastrorillo et al. 2022; FAO and OPM 2018).

Yet, in the affective and political landscape of Palabek settlement, like elsewhere in Uganda, even stating the obvious posed very real risks. From the perspective of mental health workers, referring people from the mental health clinic to livelihood organisations on the basis that their suffering was grounded in their living circumstances would require an acknowledgement of the inadequacies and failures of the Ugandan response. This, in turn, inevitably entails an admission of the reality of widespread corruption (O'Byrne 2021; Titeca 2022) which, despite being an open secret among humanitarian workers and OPM officials

[64] In Chapter 4, I have described in an ethnographic vignette an exceedingly rare event, in which one NGO worker did explicitly mention one significant failure of the refugee response to the group of refugees to whom he was delivering a financial training (see p.121). However, even in that context the failure was openly discussed as an 'opportunity' for refugees' entrepreneurship.

operating in the settlement, remains a taboo subject – or, at the very least, an open criticism of one of the governments' most highly valued and profitable operations. Coherently with dynamics of 'institutional arbitrariness' (Tapscott 2021), the repercussions on individuals who would make such a public statement were hard to foresee. This was compounded by the high volatility of NGO contracts in Palabek, subject to constant and often unexplained turnover. It was a well-known fact, for example, that NGO workers whose corruption had been irrefutably exposed were transferred to other settlements or made redundant; it is possible that transfers and dismissals could be weaponised as punishments in other cases, too.[65] Forms of arbitrary governance are predicated precisely on the strategic unpredictability of consequences and risks which can befall individuals, creating an "ecology of fear" (Das 2007:9) which profoundly permeates daily life and social relations. Fear, as Stevenson (2020) shows, is a powerful social regulatory mechanism, as well as a frequent mode of governance in authoritarian settings – and particularly in Uganda, where through the employment of arbitrary violence a "largely absent state can appear […] to be present" (Tapscott 2021:15).

Whether out of helplessness or fear, mental health workers (along with most of their colleagues) remained silent and at least publicly disengaged from what refugees repeatedly reported – the role of present circumstances in causing overthinking, hopelessness, and despair. Doctors' selective avoidance to acknowledge and validate refugees' circumstances was situated within a relationship already characterised by deep mistrust, resulting from refugees' awareness and lived experiences of the corruption and inadequacies of the refugee response. This diffused suspicion seeped into clinical encounters. Here, the feeling that complaints about present circumstances were being dismissed in clinical encounters reproduced and confirmed refugees' frustrations; at the same time, it identified mental health workers not only as part of the same establishment as other NGOs, but also ultimately uninterested in their wellbeing.

This perception clearly emerged from refugees' experiential accounts of psychopharmacological treatment. At the end of a long interview, Patrick and I sat with Irene at the edge of her compound. The giggling of two of her grandchildren could be heard nearby. While chatting with us, Irene also listened intently to them, warning them whenever

[65] This consideration echoes work on corruption in developing democracies; Wade (1982) showed that transfers are a powerful means of control in India, while more recently Brierley's (2020) work in Ghana shows that politicians enact corruption by threatening to transfer officers who refuse to facilitate their illicit appropriation of public funds.

their playing turned into arguments (*"Tuk mot!"* she exclaimed, *"Play gently!"*). A small pile of cassava, which she had received as payment for two days of heavy labour, weeding the nearby garden of a Ugandan citizen, waited to be peeled next to the kitchen door. Irene asked me if I thought that the medication that she had been prescribed would help her. I replied that though I hoped so, I could not be certain. After a moment of silence, she stated, gently but nonetheless adamantly: *"The medicine cannot do anything to me to have less thoughts. I will only have less thoughts when I can support my* [grand]*children. I will sleep when they are satisfied."*[66]

Okot, an Acholi-speaking refugee in his forties, had been tormented by bad spirits since, at an early age, he was kidnapped by the Lord's Resistance Army in South Sudan alongside his father and two brothers; he was the only one who came back alive. His mother, with whom he lived in Palabek, had consulted several spirit mediums (ajwaki), but the 'cen' kept coming back. As a result of the continuous spirit attacks, when I met him he carried on his body some of the unmistakeable characteristics of a 'laman' (mad man); [67] his appearance was unkempt, his speech often incoherent, and he was known to be often rude ('laranyi') to neighbours, who laughed at him, commenting that his head had been 'spoiled' ('wii ye obalo'). The mental health clinic in Palabek settlement was his first encounter with biomedical psychiatry; here, he had been diagnosed with schizophrenia and severe PTSD, and prescribed CPZ. [68]

Okot spoke at length of South Sudan; he keenly listened to the radio, following the progress of fragile peace talks between Riek Machar and Salva Kiir. He particularly missed working on his land; despite his spiritual problems, he had been able to keep digging and weeding his garden, along with his mother. He resented life in Palabek for the same reasons most of my interlocutors did, and often lamented feeling idle, as well as the lack of food and soap. He did not trust NGO workers, and particularly feared the Health Centres; he recounted that one

[66] Irene used the Acholi word 'yeng', indicating satisfaction from a full stomach.
[67] The South Sudanese Acholi word for 'mad man', 'laman', carries the same meaning as the Ugandan Acholi term 'lapoya', more frequently found in the literature on Acholi notions of mental illness and health (see e.g., Williams 2021; Victor 2018).
[68] Samuel and I had several exchanges with Okot, despite encountering his rudeness first hand. The first time we approached his compound, which I had previously visited with a mental health worker, he yelled at us and gestured to leave him alone; we immediately left amidst the laughs of his neighbours. We returned after consulting his mother, who was used to his outbursts and eager to talk to us. She insisted we came back, apologising for his behaviour. I was concerned about the ethics of attempting a second visit, given Okot's clear refusal to talk. We agreed that his mother would be present for the conversation, and that we would not insist further in case he refused again. However, the next time we visited him Okot was happy to talk. Unprompted, he explained that he had chased us away because we thought we were NGO workers (a misjudgement which my whiteness often elicited).

time, drawing blood from his arm for a malaria test, they had taken his soul ('tipu') away.[69] He would only get it back, he explained, *"when we go back to South Sudan"*. He felt particularly bitter about the issue of his CPZ medication, which he had discontinued despite the insistence and home visits of mental health workers. He did not like feeling dizzy and feared the medication-induced sleepiness. However, the main reason why Okot recounted abandoning treatment was that he understood the medication to be 'useless' ('moa') for his condition. He explained: *"These doctors don't listen. They keep giving me pills, but they don't want to cure my real sickness"*. I asked what sickness that was: *"The one that makes me sit like this, idle, all day"*, Okot replied.

Okot's observations point to the core of the issues discussed so far in this chapter. In describing the lack of an occupation, structure, and scope as his 'real' sickness, Okot identified his suffering as directly caused by living and material conditions of displacement, and doctors' disengagement with his priorities as a source of frustration and mistrust. A similar perspective, where the medication's side effects came to embody refugees' perception of the humanitarian apparatus' lack of meaningful care, came from Francis, an Acholi-speaking refugee in his late twenties who had been diagnosed with bipolar disorder. Having recently moved into the settlement after being long estranged from his family, he found sitting at home extremely hard. He had to go look for money, he explained. With very limited social connections in the settlement, walking around in search for temporary jobs was Francis' main occupation; when he could not find work, he started to beg for money. When asked about why he interrupted the CPZ treatment he had been prescribed, he shrugged and unambiguously stated: *"I can't move around if I sleep all day. It's like the doctor wants you to have no life"*.

Symbolic efficacy plays a fundamental part in determining outcomes of medical treatment (Van der Geest and Whyte 1989; Etkin 1992). In this context, prescription of psychopharmacological treatment is perceived by refugees as doctors' only response to their suffering, making Palabek settlement's mental health clinic an example of what Jain and Jadhav have called "administrative psychiatry" (2009:64), whose primary goal is "the prescription of psychotropic drugs and the reduction of symptoms, rather than addressing the social or psychological factors which may contribute to mental breakdown and recovery"

[69] It is worth noting here that, as O'Byrne (2016:100) describes at length, the notion of tipu among South Sudanese Acholi is closely linked to ideas of relational and moral personhood, the relevance of which for life in displacement has been discussed at length in this chapter.

(Read 2012:441). In bringing to the fore and potentially exacerbating the very circumstances at the root of refugees' hardship through its side-effects, for refugees "[psychiatric] medication becomes […] the sign of the helping profession's inability to help" (Luhrmann 2011:185), embodying the humanitarian system's disregard for their socio-economic and material circumstances.

Furthermore, by highlighting the gap between symptom reduction and material support, medication reproduces a feeling of being 'managed', rather than being 'helped' – reminiscent of the 'control-over-care' paradigm described by Farmer (2020) in the context of public health responses to the 2014 Ebola epidemic in West Africa. Medical artifacts retain a strong symbolic quality (Turner 1967), mediating the relationship between individuals and the wider medical establishment (Van der Geest and Whyte 1989; Tran et al. 2020). As shown by Van der Geest and Whyte (1989), "even removed from their medical context, [medicines] retain a potential connection to it. The medicines have a metonymic association with medical doctors who prescribe them" (ibid:360). Non-compliance with medication, especially when it is accompanied by a withdrawal from mental health services, communicates the rejection of a form of care deemed inadequate or ineffective in the face of the "extraordinary conditions" of life in Palabek. Non-compliance with psychiatric treatment in Palabek settlement needs to be understood as a relational response to perceptions of institutional abandonment, and as such a way for refugees to meet the humanitarian apparatus' disengagement from their unmet needs with the same relational currency.

5. Discussion

The lack of experience-near research in global mental health obscures the reasons underlying refugees' choices and perceptions, instead constructing them as the result of poor decision-making underpinned by ignorance or irrational 'beliefs'; however, resistance to medication should not be understood in isolation from the socio-economic and political context when it takes place. Non-compliance with treatment is not just a product of clinical relationships, but of a socio-political order as well (Tran and colleagues 2020:81; Jain and Jadhav 2009).

Crucially, where psychoactive medication represents the main form through which care is provided, any relationship with health services is bound to become mediated by and communicated through the treatment as well; its rejection or discontinuation – that is,

people's 'non-compliance' – is to be read therefore as individuals' expressions of disengagement with the care infrastructure (Jenkins and Kozelka 2017; Tran et al. 2020). Refugees' non-compliance with psychiatric treatment points to a fundamental bind that characterises the relationship that refugees in Palabek entertain with the humanitarian apparatus. An appreciation of the relational complexities of both silent and vocal negotiations around treatment shows that practices revolving around psychiatric pills in Palabek embody a tension constitutive of refugees' experiences of the institutions that influence their lives in displacement. The same tension, I argue, significantly weighs both on refugees' attitudes towards treatment and on treatment efficacy.

From the material presented in this chapter, non-compliance becomes readable as an agentic relational strategy serving two main purposes. Firstly, it creates a channel of communication with a humanitarian establishment unwilling to recognise either refugees' priorities, or its own shortcomings. Non-compliance in Palabek settlement can be characterised as what medical anthropologist Byron Good has termed "eruption of the political" (2012:528) – an instance in which "that which is largely unspeakable is partially spoken" (Chua 2018:25). Secondly, it allows for a reprioritisation of social functioning for those who enact it. Cheryl Mattingly (2014:20) has put forward the notion of 'moral experiments' to understand how individuals who find their sense of integrity, their social roles, and their capabilities jeopardised by psychiatric diagnoses and treatment may re-negotiate their moral identities under structural violence, as well as material constraints (Myers and Yarris 2019). In light of considerations of Acholi moral and relational dimensions of personhood, non-compliance with psychiatric medication represents a 'moral experiment' through which refugees work to reassert a social and moral identity in the context of extraordinary conditions, as well as to assert some degree of control and of moral order on the world.

To understand resistance to medication as simply the expression of an individual preference would be too simplistic and would perpetuates the idea of non-compliance as stemming simply from the irrationality of a disturbed mental state; to some extent, non-compliance should be understood as constituting a critique of the local humanitarian hegemony and of psychocentric intervention models. I refrain, however, from characterising it as a 'practice of resistance' to structures of power. Post-colonial contributions caution against the epistemic injustice (Chapter 1) embedded in the over-interpretation of interlocutors' actions and narratives, particularly in cases in which these have unfolded in acute states of suffering. As argued by Kirmayer, "imputing agency or communicative intent to symptoms when people

feel out of control […] appropriates the experience of the sufferer to launch a critique of structures of inequity in society" (2020:268). For this reason, while Chua argues that psychopharmaceuticals act as "agents of revelation and reform" (2018:27) for military veterans in the US, I am sceptical of understanding behaviours related to psychiatric treatment in the same way in Palabek refugee settlement. I seek, however, to find a middle ground through which to acknowledge and contain research participants' moral and agentic choices and experiences, without ascribing to non-compliance ideological ambitions that they may not recognise as their own.

Despite the atmosphere of fear and suspicion that characterise its emotional landscape, as well as the lifeworlds of many of its residents, Palabek has at times been a site of resistance. O'Byrne (2021) documented here refugees vocally protesting food scarcity and the corruption of the local humanitarian apparatus, describing these events as forms of 'everyday resistance'. Things are different, however, for non-compliance. Because the prescription of psychopharmaceutical treatment concerns relatively few people, whose conditions are often heavily stigmatised (Mugisha et al. 2019), challenges associated with it are hardly openly discussed – unlike issues related to food distribution. Thus, non-compliance hardly possesses the transformative power of collective mobilisation; it lacks an organisational and solidarity-based component that would qualify it as a such. Despite being at its core a relational act with deep political implications, ultimately it remains an individual choice – one that is in itself unlikely to effect change, but nevertheless involves significant personal costs. [70]

This was particularly manifest in the case of Justin and his continued relapses. When I first met him in early 2019, he talked often about the future; he was anxious, but purposeful, and kept interrogating himself on how to find a job. This radically changed over the following months, during which he had interrupted treatment and relapsed several times. When I visited him at his uncle Ojara's for the first time since he had moved there, in January 2020, he looked healthy and well-nourished – yet exhausted, and hopeless. I asked him whether he was still looking for a job, and whether he had any plans for his future. *"There's no plan",* he replied with an embarrassed chuckle. He added:

[70] In this sense, non-compliance resembles the 'pragmatic mobilities' (O'Byrne and Ogeno 2020) of refugees who return to South Sudan, temporarily or permanently. Both these choices are made in an effort to reprioritise the search for a moral life; and equally, both expose the individual to significant personal risks, while carrying limited potential to meaningfully challenge the status quo.

"You just have to stay at home like this. There's no plan completely. […] Because I cannot plan that 'I need to do A B C D…' when the resources are not there. My worst enemy now is this sickness here. When I'm trying to plan something here, it's always interrupting me. I have no hope. The more I'm sick, the more I feel like maybe I should just end my life".

While it is impossible to ascertain whether Justin's sickness would have followed the same downward trajectory in the absence of repeated relapses, it is worth remembering that non-adherence to psychopharmaceuticals is linked to severe risks, including exacerbation of symptoms and increased suicidality (Farooq et al. 2014). Repeated cycles of withdrawal from treatment and relapses can be understood as themselves producing forms of chronicity such as those echoed in Justin's words, resulting in experiences of 'social defeat' (Luhrmann 2007). There is a real risk, therefore, that psychopharmaceutical prescription in complex political and low-resource settings, such as Palabek refugee settlement, may accelerate sickness and exacerbate forms of affliction, impairing people's ability to strive towards what they deem to be a 'good life'.

6. Conclusion

When prescribed appropriately, within therapeutic relationships, and with considerations of the medications' interaction with ecological and contextual elements, psychopharmaceuticals can improve people's psychological suffering, restore social functioning, and allow for individuals to feel hopeful and valued. In this chapter, I have shown the harm that occurs when this is not the case. I have also demonstrated the arbitrary nature of the distinction between 'primary' and 'secondary' effects of medication (see Chua 2018; Read 2012). In their interactions with conditions of chronic poverty and food insecurity, side-effects magnify conditions of afflictions, thus subverting the "rigid hierarchy of risk and value" (Davis 2018:6) on which the categorisation of medications' effects is predicated.

Non-compliance in Palabek settlement should be largely understood as actively produced by the social injustices populating refugees' social and moral worlds. [71] The risks are real and

[71] This echoes recent anthropological studies of marginalised groups' engagement with the health system during the Covid-19 pandemic in Europe. Among these groups, too, mistrust in healthcare institutions was a product of systemic inequalities and marginalisation which individuals and communities had experienced at

significant; not only does psychiatric treatment prescription in Palabek refugee settlement force refugees to face impossible dilemmas, between psychological health and family survival, but it also exposes individuals to the psychological and existential risks caused by inconsistent treatment. This, I argue, constitutes structural violence.

Because of the expansion that psychopharmaceuticals are currently undergoing in the Global South, more people are likely to face similar circumstances. Crucially, the individuals most likely to be negatively affected by side-effects of psychotropic treatment are those who have already been particularly struggling in displacement. What the experiential accounts offered here share, is that they belong to people who cannot rely on extended networks for financial, material, and emotional support (with the exception of Justin, when his sickness worsened significantly); who cannot capitalise on pre-existing resources; and who do not have access to land to cultivate outside of the settlement.

These considerations should raise serious questions around the sustainability and, especially, the ethics of implementation of this kind of intervention. In his wide and inspiring scholarship, Paul Farmer often highlighted the links between global health interventions and forms of social (in)justice, and explicitly identified the distribution of less effective treatment to patients in poorer nations as a human rights violation (ibid. 2004). That emergencies in resource-poor settings in the Global South still rely almost exclusively on first generation antipsychotics and antidepressants, which the Global North has by now largely discarded, should be urgently corrected. Even then, however, the main issue would remain unresolved. Until refugee policy and global mental health take seriously refugees' priorities and engage with the role of context and structural determinants of distress, mental health interventions will be doing little for refugees' wellbeing; instead, they may inadvertently produce mistrust, hopelessness, and real harm.

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the hands of the state, significantly impacting their engagement with public health mandates (see Storer et al. 2022).

Chapter 8. Suspended: a phenomenological exploration into masculinities, mental illness, and temporal dispossession in South Sudanese refugees' displacement in Uganda

1. Simon's story

In March 2019, Simon[72] entered the small and often unbearably hot room where a mental health clinic was held weekly in Palabek refugee settlement, in the northern Ugandan district of Lamwo. As soon as he sat down, it was clear that it was not his first time there. The psychiatric nurse greeted him warmly, then turned to the psychiatric officer sitting beside him, with a knowing smile: *"This is the one I have been telling you about",* he said. The psychiatric officer nodded, then went back to checking his phone. Slightly annoyed, the nurse turned again to the quiet man sitting in front of him, leaning back in a white plastic chair that was far too small for him. *"We have been managing him for Major Depression with amitriptyline"*, he said out loud, for his colleague's benefit and mine. "*He also has an erectile dysfunction disturbing him"*, he added. The psychiatric nurse explained that Simon's suffered from depression and frequent suicidal ideation, caused by *"a history of trauma"*. In addition, the *"erectile dysfunction is perpetuating the depression…but things are improving. Now it* [the depression] *has changed to moderate thanks to the medication."* Simon finally spoke up, disagreeing with the nurse's optimistic assessment of his situation. He recounted that in the past two weeks things had gotten worse, and despite complying with the medication and following the doctors' advice, he had not been able to have sex with his wife. The psychiatric nurse did not respond to his remarks, repeating instead once more: *"The drug is working well".* Upon hearing that treatment should be continued, Simon looked away in silence, his gaze distant.

A tall and kind-looking 36-year-old Acholi man, Simon was originally from the village of Pajok, South Sudan, where he was a farmer. In April 2017, during a sudden increase in military violence against civilians in the southern Eastern Equatoria state, Pajok was attacked by the South Sudanese government army, the South Sudan People's Defence Forces or SPLA (O'Byrne 2022; Human Rights Watch 2018). Thousands of refugees, largely belonging to the

[72] All names have been changed.

Acholi-speaking group, crossed the nearby border into Uganda's northern region, where Palabek refugee settlement was established to host them. During the attack, Simon was abducted by SPLA soldiers, who tortured him and forced him to bury several dead bodies. After weeks of captivity, Simon managed to escape and join his wife and children in Uganda.

Since arriving in Palabek, however, he suffered from severe pain all over his body, and especially from constant erectile dysfunction. He attributed both these issues to the torture he was subjected to by the SPLA soldiers, and was particularly worried about his erectile dysfunction, which he expressed experiencing with a mixture of hopelessness, anxiety, and fear. The thought of his wife Rose leaving him particularly troubled him: *"My worry now is that since she is not getting sex from me she might go and cheat, since she is still young and I cannot meet her needs"*, he explained. *"I am afraid I will be left alone"*. After consulting a traditional healer without success, Simon went to look for medical help at the main Health Centre in Palabek, where after a quick assessment of his symptomatology he was referred to the psychiatric staff at the settlement's mental health clinic. Once they heard his story, the mental health professionals diagnosed him with post-traumatic stress-related depression. Simon was put on a treatment of amitriptyline, a first-generation antidepressant commonly prescribed in humanitarian settings worldwide When I met him, Simon had been taking the antidepressant for several months; despite his continuous requests, he had not received the physical examination that he was hoping for, and his erectile dysfunction had not gotten any better – nor, for that matter, had his affliction, which he referred to as 'overthinking' ('tam ma dwong')[73]. Talking about his life before the war, Simon would say: "*By then I was a man, the man in the house, and I could satisfy my wife's needs. But these days I am useless, and I am thinking of ending my life"*.

Crucially, however, Simon's suffering and anxieties around his identity as a man were not solely elicited by his painful experience of erectile dysfunction. Rather, they need to be understood as closely linked to the identity implications of the harsh socio-economic conditions of his life in displacement in Uganda. While he had been a farmer on his ancestral land in Pajok, in Palabek refugee settlement he found himself largely unable to farm or work.

[73] The idiom of 'overthinking' / 'thinking too much', widespread throughout Sub-Saharan Africa, carries a slightly different connotation than that of British English. The idiom has been noted to be used to describe a variety of psychological and psychosomatic symptoms, often similar to depressive states. However, several scholars have cautioned against the conflation of 'overthinking' with psychiatric categories originating in the Global North, such as depression (Backe et al. 2021; Kaiser et al. 2015; Adaku et al. 2016)

He tried to stay busy. Occasionally, he would do odd jobs for Ugandan citizens living around the settlement; he would lay bricks, or help building a new grass thatch roof for somebody's hut. Sometimes he helped a friend who had set up a small shop in the settlement, repairing bicycles. Most days, however, he spent sitting at home or in one of the trading centres of the settlement. The feeling of being unable to meaningfully provide for his family particularly affected him, seemingly confirming the worries elicited by his erectile dysfunction. The cycle of fears and anxieties these factors elicited around Simon's sense of personhood and masculinity deeply affected his mental health. Although he often reported the lack of any improvement in his erectile dysfunction during several follow up visits at the mental health clinic, the doctors insisted that he continue taking the medication.

After several months of seeing no change in his erectile dysfunction, Simon grew frustrated with the doctors, whom he perceived as unwilling to listen to his concerns. He gave up the medication he had been prescribed and stopped going for regular check-ups at the mental health clinic. He eventually took up drinking alcohol – a habit that he had never had before coming to Palabek refugee settlement. His affliction, worsened. Often he said he thought of going back to Pajok, where he could at least farm on his land and earn some money to support his family: *"I am now useless. Even though South Sudan is in bad conditions, I think that I should go back there and work, or hang myself"*. After all, Simon added with a sad smile, *"going back to South Sudan is a way to die"*.

2. The case for a temporality-centred framework to understand displacement, gender and mental disorder

Recent academic work has highlighted the way humanitarian programmes have approached issues of gender in the implementation of their programmes in emergency settings. The prominent framing of "gender" that came to light with the World Humanitarian Summit of 2016, and with the subsequent UN Woman, Peace and Security (WPS) agenda, proposed 'gender equality' as a priority. However, as Hilhorst and colleagues have pointed out, "the humanitarian community still has a tendency to say 'gender', when in practice it means women and girls" (2018:5). While men are associated with perpetrating violence and (self)destructive behaviours, women are seen as both more vulnerable and reliable, more likely to be the object of violence and to use resources for the well-being of the family

instead of wasting them (Hilhorst, 2016). Altogether, the gendered regimes of care that dominate the field have led to a disproportionate focus on to "womenandchildren" (Enloe 1993:165) as beneficiaries of empowerment and interventions, and as objects of study in humanitarian contexts. On the other hand, men have often been excluded by aid programmes, and issues related to masculinity frequently side-lined in both humanitarian action and public debate (Krystalli 2018; Turner 2019). There is a need for analytical ways of understanding experiences of men, interrogating nuances and changes in their sense of manhood and masculinity in contexts of crisis and instability, where gender dynamics are often thrown into disarray (Dolan 2002).

Following Lems' methodological suggestion to "zoom in" on refugees' lifeworlds (2016:315), in this article I use Simon's story as a point of departure from which to offer a reflection on the lived experiences of masculinity and suffering in a displacement context. Many other refugee men with whom I spoke during my fieldwork gave accounts similar to Simon's of their own lives in Palabek settlement. The personal circumstances and life stories of Simon and other interlocutors varied greatly; yet, what their afflictions have in common is a deep anxiety about the present and future of their status as men, exacerbated by displacement, but with deep and complex roots and ramifications.

During my fieldwork, I was able to closely follow Simon's case for more than one year through weekly visits to his home, countless discussions and interviews with him, his wife, and his clinicians. Over the time I spent with him and his family, it became clear to me that understanding his predicament necessitated an appreciation of the intersection of issues of displacement, gender, and mental illness, which emerge as crucial from Simon's story. To explore this, I try to go beyond a discussion of the clinical manifestations of mental illness and social suffering, highlighting instead the links between Simon's (and others refugee men's) affliction, and Ugandan and international institutions' responsibility in creating and fostering their suffering. I argue that to make such links visible, the interrelation of masculinities, displacement, and mental health, needs to be analysed in close relation to notions of temporality, and as a phenomenological manifestation of what Ramsay has termed "temporal dispossession" – that is, an experience where "the possibility of a self-directed future is constrained by external forces, and particularly those that derive from processes of dispossession" (2020:388).

Temporality is a fundamental axis structuring human existence, so that "our past experience is always retained in a present moment that is feeding forward to anticipate future horizons of experience" (Desjarlais and Throop 2011:88). Usually understood as the experiential quality of the passage of time and the relationship with imageries of past and future, temporality has a long tradition of being a crucial concept in the study of modernity, development, and global capitalism (Ho 2021). Recently, the concept is experiencing a revival, with anthropological scholarship increasingly identifying temporality as key to understand and measure inequalities – particularly in forced displacement situations (Bear 2016; Ramsay 2020; Haas 2017). In the context of refugee lives, a temporality-informed analysis allows for a rethinking of how displacement is experientially inhabited, in at least three main ways. Firstly, by bringing to the fore socio-political processes and complex systems of power shaping conditions of displacement; secondly, by expanding phenomenological understandings of gendered experiences of displacement; and, finally, by offering an explanatory model as to why the mental health care currently offered in Palabek settlement and in many other refugee settings worldwide may be perceived as unhelpful and misplaced by refugees themselves.

At the time of writing, over 108.4 million people are forcibly displaced worldwide (UNHCR 2023), a figure unprecedented since World War II and anticipated to increase exponentially over the next decades. In addition, the length of displacement now averages between 10 and 26 years (Weiss et al. 2017), meaning that 'protracted refugee situations' are the norm for most displaced people. These figures show that displacement is a prolonged state affecting over 1% of the world's population. This has led some scholars to point out the need to de-exceptionalise the 'refugee experience' – that is, to view and discuss displacement not as a phenomenological category in itself, but rather as a state shaped by the same dynamics of global capitalism that govern conditions of chronic poverty and social inequalities worldwide (Cabot and Ramsay 2021; Tazzioli 2021; Sakti and Amrith 2022).

To explore experiences of displacement, anthropological scholarship has often mobilized ideas of 'stuckness' and 'uncertainty'. Both concepts, however, have been identified as problematic and inadequate in accounting for refugees' lived experiences. Firstly, as noted by Jefferson et al. (2019), ideas of 'stuckness' have been until recently dominated by a spatial bias – that is, by a tendency to understand the experience of being 'stuck' primarily as a constraint to spatial mobility. However, as Jensen (2014) points out, even contexts where 'stuckness' entails the absolute confinement of imprisonment are characterised by constant

relational dynamism. In Simon's case, understanding displacement as characterised only by spatial 'stuckness' makes it impossible to grasp the hardship that Simon and many other refugees experience in Palabek settlement. In Uganda, where the country's laws grant refugees freedom of movement, refugees regularly travel around and between settlements, to other parts of the country and even back and forth to South Sudan (O'Byrne and Ogeno 2020). In the relative absence of spatial constraints, 'stuckness' becomes more helpful when conceptualised as a complex and multidimensional quality of confined experience, which may include, but cannot be reduced to, limitations on mobility.

Secondly, the experience of displacement is often described as dominated by widespread uncertainty. Uncertainty, sometimes operationalised through concepts of 'precariousness' (e.g., Sampson et al. 2016) or 'being in limbo' (e.g., Hartonen et al. 2021), is understood as a defining and intrinsic characteristic of displacement, and as the main explanatory mechanism accounting for every aspect of life in displacement (Horst and Grabska 2015; Parkinson and Behrouzan 2015). Much research on refugees' wellbeing tends to explain refugees' mental disorders as resulting from prolonged experiences of uncertainty, described as something with which refugees are required to 'cope', while failure to do so is understood to cause stress, anxiety, and depression (Grabska and Fanjoy 2015; El-Sharaawi 2015; Bjertrup et al. 2018).

However, as pointed out by Schiltz and colleagues (2018), discussions of refugees' experiences that widely and uncritically adopt ideas of 'uncertainty' tend to essentialise conditions of displacement. Such narratives, the authors note, are often vague and ill-defined, assuming the universal characterisation of displacement to be one of instability and uncertainty. Displacement does not occur under the same circumstances, to the same people, or for the same reasons, everywhere. Often, for example, uncertainty in displacement is characterised as a sense of precariousness related to an insecure legal status (Beneduce 2008; Cange et al. 2019), which often require people to withstand long periods of 'waiting' for asylum status (Haas 2017, 2023; Brun 2015; Bjertrup et al. 2018; Sanyal 2018;) in a 'legal limbo' (e.g., Menjivar 2006; Biehl 2015). However, Uganda grants South Sudanese refugee status on a *prima facie* basis, as well as freedom of movement, the right to work and access to the same basic services as citizens (United Nations and World Bank 2017). Simon's affliction therefore escapes the categorisations of phenomenological perspectives of forced migration rooted in spatial frameworks of confinement or focused on circumstances of legal uncertainty

– demonstrating the need for new theoretical understandings of refugees' experiences of displacement (Ramsay 2017).

While notions of uncertainty and spatial stuckness are widely used as heuristic tools in the study of psychological suffering in displacement, studies focusing on these terms tell us little about how refugees experientially inhabit displacement (Lems 2016). The overuse of vague narratives in characterising displacement, such as those revolving around uncertainty or 'stuckness', also risks obscuring complex historical and social relations shaping displacement (Ramsay 2020; Biehl 2015), contributing to the dehistoricisation of refugees and forced migrants (Malkki 1996). Building on these considerations, recent scholarship has argued for the need to understand refugees' phenomenological experiences of displacement as a reaction to the global political and socio-economic structures that govern them (e.g., Ramsay 2020; Haas 2017; El-Shaarawi 2021). Scholars have argued that temporality provides a much-needed window into the lived experiences of refugees and the systems of power that govern displacement. Displacement, after all, is the state *par excellence* in which the temporal continuity of life, crucial to people's sense of self, is interrupted (Fathi 2021); as argued by Jefferson and colleagues, "the un-freedom of confinement is often more temporal than spatial" (2019:6). The particular relationship with time, which characterises displacement allows for an expansion of the conceptualisation of confinement beyond the hindrance to mobility (Díaz Letelier 2022). Notions of "temporal stuckness" (Jefferson and Segal 2019), "temporal uncertainties" (Griffiths 2014) and "temporal liminality" (El-Sharaawi 2015) have been mobilised to bring a time perspective to the study of displacement. Experiencing displacement, in other words, often has more to do with the possibility of future-making, and the extent to which socio-political circumstances allow for this (Schiltz et al. 2019).

In this article, I build on Georgina Ramsay (2020)'s concept of 'temporal dispossession' as central to understanding conditions of displacement. Ramsay defines displacement as "an existential experience of contested temporal being, in which a person cannot reconcile the contemporary circumstances of their life with their aspirations for, and sense of, the future" (2020:38). Displacement, rather than simply creating states of liminality, uncertainty or waiting which all imply a possible resolution, represents a "fundamental disruption of the teleology of life" (ibid.), in which "a sense of going somewhere in life" (Hage 2005:474), and of 'being-in-time' (Heidegger 1962 in Stolorow 2003), is shattered. Displacement, in this sense, does not simply freeze the trajectories of refugees' lives; rather, it fundamentally

dispossesses refugees of their time, of the possibility of not just acting towards strategies of future-making – but even of projecting, or imagining, themselves into the future. This, in turn, produces social conditions of insecurity and experiential states of contingency, in which one's life is controlled by external forces that "cannot be fully foreseen or controlled" (Whyte 2009:214). An attention to the phenomenological experience of such states is necessary to understand psychological affliction in displacement. Crucially, the notion of 'temporal dispossession' emphasises the socio-political processes that generate displacement situations (Çaglar and Glick Schiller 2018), noting that such processes are firmly rooted in capitalist logics of accumulation for profit, which govern neoliberal global migration regimes (Aradau and Tazzioli 2020), including the Ugandan case (Torre 2023).

3. Context and methods

This article is based on fourteen months of in-depth ethnographic fieldwork which I conducted between October 2018 and March 2020 among South Sudanese refugees in Palabek refugee settlement, situated in Lamwo District, northern Uganda. Since a brutal civil war began in South Sudan in 2013, more than 2.5 million people have sought shelter in neighbouring countries (UNHCR 2022). Uganda now hosts close to a million South Sudanese people, more than any other country, and this number is likely to increase due to the continued instability of South Sudan's security situation (ibid), where past ceasefires have been unreliable. During my fieldwork, I lived with a family of Acholi-speaking South Sudanese refugees residing in Palabek settlement. I followed the work of several different organisations operating in the field of mental health in the settlement, studying encounters between NGOs and refugees' often diverging understandings of, and approaches, to psychological suffering. In particular, I closely followed the lives of several Acholi men of various ages and social status over more than one year, focusing especially on experiences of masculinity and life in displacement.

4. Temporal dispossession and self-reliance in Palabek refugee settlement

Simon's anxieties around his status as a man had implications extending far beyond the sexual sphere and need to be understood as closely related to the harsh socio-economic conditions of his life in displacement. Sitting on a small wooden bench under the modest but

reliable shade of the tree in the middle of his compound, Simon pointed to a small garden which barely fitted between the kitchen and the two huts he built: *"We have a very small plot. This is the only piece of land they have given for construction of huts and latrine, in the remaining piece you plant some greens – that is all*", he explained. As new refugee arrivals in Uganda, Simon and his family were allocated a plot of land of thirty-by-thirty metres in Palabek. This is one of the main points of Uganda's 'self-reliance' approach to refugee management, which is based on the principle that refugees have the capacity and skills to become economically independent from humanitarian aid, and grants refugees the right to work and a small plot of land to use for both housing and cultivation purposes. The approach has received widespread praise for being progressive and 'development-oriented' (World Bank 2016). In reality, however, a combination of poor implementation of 'self-reliance' policies across the country and significant shortcomings, corruption and failures in the distribution of humanitarian aid to refugees have resulted in most people in Palabek and other settlements in Uganda living in chronic poverty and frequent food insecurity (Torre 2023; O'Byrne and Ogeno 2020; Titeca 2022).

Like many others, Simon was unable to obtain any economic gain from working on his plot in Palabek, nor to find stable employment within or outside the settlement. Palabek is located in Lamwo District, a remote and economically moribund region of Uganda where finding stable employment is rare. The small size of the plots assigned to refugees make farming for economic gain unrealistic (Bohnet and Schmitz-Pranghe 2019), and the land allocated to refugees in Uganda often proves infertile after short periods of time (Berke and Larsen 2022). Simon and his family had planted tomatoes and cassava on their plot, but the yield was insufficient to enable them to stop relying on humanitarian assistance in the settlement. The small harvest had to fill the gaps left by the continuous reduction of food aid distributed in the settlements, which has had been insufficient since the beginning of the current refugee response in 2015/2016, and diminishing for years (Krause 2016). Partly, these reductions are due to the chronically underfunded and corruption-riddled nature of Uganda's refugee response (O'Byrne 2022; Titeca 2022). The downscaling of food assistance was also justified through a misguided political narrative from Ugandan refugee institutions that have *de facto* declared an end to the emergency phase of the response (Torre 2023; Green 2018). In this climate, both aligned with and fuelled by Uganda's recent neoliberal policy landscape, refugees are expected to gain independence from humanitarian assistance by 'being entrepreneurial' and using their plots of land to sell their harvest and build capital, or by

finding employment in the areas surrounding the settlements. However, inadequate and declining food assistance mean that refugees' plots of land in Palabek serve purposes of survival rather than self-reliance.

In Palabek, the lack of land and the pseudo-implementation of refugee self-reliance policies contribute to the temporal dispossession that refugees experience in displacement, affecting their chances of fulfilling gender roles, and planning for their future and moving towards it. Echoing Frederiksen and Dalsgård's (2014) observation that time is both inherently materialized and social, I propose that land can be therefore conceptualised in a temporal sense too – that is, as a physical and geographical element with temporal and social significance. It is more than a fundamental resource and basis for survival and economic growth; rather, it is a temporal landscape of future possibilities. In Simon's words:

> *"Back in Pajok life was good. You could cultivate and get a good harvest which could help you in all ways, like with paying school fees for children and in case of sickness. You could farm as much as you wanted. But here I don't have any work to do. I am just trying to plant vegetables".*

With inadequate humanitarian assistance to build a solid foundation, scarce possibilities of economic entrepreneurship, and plots of land too small to earn any meaningful income, the future is difficult to plan and a sense of moral personhood challenging to maintain. The close relationship between land and future-making emerges clearly through the words of Rwot Oceng, the 'traditional leader' of the Pajok community:

> *"It is impossible to plan here, because there is no land to cultivate. People here overthink because there is nowhere to dig. In South Sudan, people could harvest and get some money – that would give you hope, and you could help your family."*

Everyday life in Palabek is not characterised by a passive state; most refugees are constantly on the lookout for stable job opportunities. However, often all that is available to them is 'leja-leja', a term with derogatory connotations that indicates performing ad hoc and underpaid farming and construction jobs on someone else's land. Women were often involved in forms of petty trade ('awaro'). Some, particularly single mothers, reported occasionally performing leja-leja as well; ultimately, however, with gendered division of labour meaning that women's responsibilities revolved primarily around running the household and the care

of children, leja-leja remained a predominantly male activity.[74] Most of the Acholi men that I encountered in Palabek had performed leja-leja at least once since their displacement, usually for Ugandan nationals that employed them for one or two days and paid them in small amounts of money or food.

The main characteristic of leja-leja is that it does not allow for planning for the future; unlike land ownership, it cannot be relied on, *"because today it is there, but tomorrow you are not sure"*, as one young Acholi man expressed. Much like temporal dispossession is to be understood not as exclusive to displacement contexts but as common to all circumstances shaped by socio-economic insecurity (Ramsay 2020), performing leja-leja is not solely a refugee experience. Many people recounted occasionally performing similar roles in Pajok as a way to gain a small income in addition to cultivating their own land. In its precarity and in the absence of land to provide an existential sense of security, belonging and personhood, however, leja-leja is a product of the temporal dispossession experienced by refugees in Palabek settlement, by virtue of being the only option available to most of them. Indeed, when asked about hopes for the future, Acholi refugees often talked about being able to return to their ancestral land in South Sudan or acquiring land in Uganda.

Most of my informants described performing leja-leja as a degrading experience, a humiliating admission of social defeat and destituteness, in that these jobs imply that the worker has no land of their own to work on and sustain himself from. *"Doing leja-leja is a terrible thing. It means that your life has become so hard that now you have to go and do it",* one young refugee commented shaking his head. He continued:

> *"If you walk carrying your hoe and say that you are coming back from working on your garden, people will say that you are very hardworking. But if you say that you are coming back from doing leja-leja, they will say 'This man has nothing'."*

The humiliation resulting from leja-leja appears therefore closely linked to temporal dispossession in two main ways: the lack of resources, and the impossibility of projecting

[74] Instances of leja-leja, alongside the gendered nature of such labour activities, have been observed in other studies based in northern Uganda and South Sudan (see e.g., Harrell-Bond 1986:241-242; Woodburn 2009:450; Wilhelm-Solomon 2016:325), and particularly in refugee settlements in this region (Payne 1998; Olwedo et al. 2008).

oneself into the future as a consequence. As emerges from the quotes above, however, men's experiences of temporal dispossession also highlight gendered nuances in their experiences of displacement, intersecting with their sense of moral and relational worth as men.

5. Masculinities in context: socio-economic, moral, and temporal dimensions

The combination of food insecurity and lack of land to cultivate in Palabek settlement means that any income that refugees may earn will be used to mitigate the precariousness of their present situation in displacement. Given the temporal connotation of land among Acholi South Sudanese, the temporal dispossession of economic resources caused by failing refugee policies in Uganda often profoundly affects refugee men's sense of personhood and masculinity, causing acute psychological suffering.

Despite the widespread understanding that gender plays an important role in shaping refugees' experiences, little is known about the impact of displacement on the mental health of refugee men (Affleck et al. 2018). Literature exploring gendered experiences of displacement points out how socio-economic challenges often cause gender norms to be disrupted (Turner 2018; Dolan 2002). Ideals of hegemonic masculinities towards which men are socialised and to which they subscribe are shaped by social practices, cultural frameworks, and moral values (Connell 2014; Porter 2013). Studies of African masculinities often identify what Hunter has called "provider masculinity" (2010:96) as particularly significant (McLean 2021). Similarly, studies of masculinities in displacement largely revolve around men's (loss of) status of 'provider and protector' (Sengupta and Calo 2016; Affleck et al. 2018; Lwambo 2013). These tropes are central to hegemonic ideals of Acholi masculinity, which emphasize "the use of masculine power to provide for and protect one's family and to father children" (Tapscott 2018:126; see also Porter 2019).

As Simon's story shows, the lack of access to land or financial resources imperils men's status as adults, even when a 'respectable masculinity' (Kleist 2010) has been attained through milestones such as marriage and fatherhood, widely regarded in Acholi-speaking (and East African) societies as particularly significant in achieving manhood. Even when they do not need to depend on leja-leja to sustain themselves or their family, the pressing necessity to earn an income often pushes refugee men to engage in precarious labour activities that

affect their masculinities and statuses as men. One young Acholi man recounted being often teased by friends in Palabek; he was the only one among them to not have a wife, as he wanted to find a stable job opportunity before starting a family. *“These boys pretend like they are men. You may have a wife, but if you cannot support her, if you are still asking your parents for things, then you are still a child”* he explained.

Globally, manhood is recognised as an unstable concept – a status never automatically conferred and in constant need of achievement, while the failure to obtain it often elicits feelings of frustration, humiliation, and shame (Porter 2013; Honwana 2014). Scholarship on masculinities across East Africa has highlighted how challenging socio-political contexts further increase men’s perceptions of being unable to assert their manhood and enact masculine roles (see e.g., Fast et al. 2020; Lwambo 2013; Silbershmidt 2001). For many young refugee men in Palabek, the precarity of their status as men is a source of great pain, as it risks forced and abrupt transitions back into boyhood. Joseph, a young refugee in Palabek, spoke with a heavy heart about his situation. While he had finished secondary school in Pajok, the lack of work opportunities in Palabek meant he worked as a motorcycle (boda-boda*)* driver within the settlement. Despite working every day, he had not been able to secure the money to pay the ‘luk’, a fee paid to a woman’s family to allow for cohabiting with her (Porter 2019; p’Bitek 1953); tired of waiting, his in-laws had recently come and taken his wife and one year old child away from him. Left alone, Joseph had gone back to live with his aunt; he greatly missed his wife and son but felt like he could not do anything about it. *“The money I make is little, here you cannot earn enough to change your life”* he said. While discussing Joseph’s story later that day, my Acholi-speaking research assistant commented: *“He is like a teenager now”*, highlighting how Joseph had effectively gone from ‘being a man’ to being disqualified as one.

Analysing displacement through a temporal lens allows us to complicate the notion of ‘provider masculinity’, making visible phenomenological aspects which would otherwise go unnoticed. Temporality impacts masculinity by virtue of the intersubjective nature of both notions. Masculinity exists not as a biological reality, but rather “as ideology […] within gendered relationships” (Kaufmann 1993:13 in Silberschmidt 2004). Simultaneously, time is inherently relational in that it is through others, and others’ expectations, that we project ourselves in the future (Frederksen and Dalsgård 2014; Jefferson et al. 2019). It is through the feeling of being synchronised to others’ time, and to the values and cultural expectations of

the society we live in, that we gain a sense of wellbeing and structure our sense of self (Fuchs 2013).

Proving to be hardworking (latic ma tek) is a prominent feature of Acholi personhood and hegemonic masculinity (Chapter 7). Yet, the feelings of humiliation and social defeat that refugee men in Palabek reported experiencing in relation to leja-leja, for example, show that Acholi ideals of provider masculinities are not fulfilled simply by performing work, or even by earning an income to support ones' family. Rather, a projection into the future through the act of planning (yubo) is necessary as well, to exercise a form of temporal agency (Flaherty et al. 2020). In the words of a young Ugandan Acholi, working as a boda-boda driver in Gulu Town: *"For us Acholi, you don't need to be rich to be a man; you are a man if, when there is a challenge, you can at least struggle and do something".* Being a 'real' Acholi man, particularly under circumstances of adversity, is contingent to the processual and future-oriented ability to work *towards* a betterment of present conditions; yet this 'struggle' depends on the availability of resources, primarily land and money, to form the basis for future-making. Crucially, this shows that masculinity is not simply articulated across moral and relational dimensions, but across temporal ones as well; it is not simply about providing in the present, but about projecting one's social and moral identity into the future through the (fluid, interrupted, and always unfinished) act of planning.

Conditions of precarity, as well as of material and temporal dispossession, pose significant challenges to achieving manhood and adulthood. Steven, an Acholi refugee in his mid-twenties, explained: *"Getting women is not a problem for me. But to get married…when you have to stay like this, with no job, and money is not there, how are you going to support her? You cannot get married"*. His teenage brother, sitting next to him, disagreed; to him, getting married and having children was a good thing even in the settlement. In response, Steven brought up their cousin Andrew, who despite not finding any way to gain money had started cohabiting with a woman he met in the settlement; they had two children. Yet, he still had to relie on his own father and uncles for financial support. "*You want to be like Andrew?"* Steven curtly warned his younger brother: "*Andrew cries every day".*

6. Experiencing temporal dispossession: refugee men and states of suspension

"I do not know what to say. My head is stuck" ('wii ya omoko'), Simon said after a long silence, at the end of an interview in December 2019 that found him particularly distressed. The exhaustion was palpable in his tone. My research assistant, who through our work together had come to know Simon well and had confided to me his fears that he would act on his suicidal ideas, tried to encourage him with words of advice and hope for the future, reminding him he was needed by his family. Simon sat with his head in his hands, listening. When his wife came into the room to bring us food to share where we sat, he quickly changed position and sat up straight.

In light of this, how can we conceptualise Simon's and other refugee men's experiences of "extraordinary conditions" (Jenkins 2015) of overthinking and displacement in Palabek? Simon's powerful description of his own state as that of his head being 'stuck' sheds light on this. Yarris and Ponting (2019) describe how experiences of mental disorder in contexts of socio-economic adversity are profoundly gendered. In a study of masculinities in post-conflict northern Uganda, Kizza et al. (2012) have discussed the impossibility to imagine and plan towards the future as a condition of "social impotence", noting that men's suicides and suicidal attempts were often grounded in an inability to perform traditional gender roles in the midst of challenging socioeconomic changes caused by the war. In an effort to understand embodiments of displacement and temporal dispossession going beyond reductive clinical categories such as 'depression', it may be helpful to conceptualise refugee men's anxieties around the performance of their masculinities, through the experiential category of *temporal suspension*. Their status as men, and thus of their moral and relational identities, are not just uncertain in relation to the future, but also suspended in the present.

For refugee men in Palabek who are unable to perform their gender identity, to experience displacement under protracted and dispossessing circumstances is to experience a suspension of (gendered) moral identity which goes far beyond a feeling of uncertainty, with wide consequences for their lives and mental health. In this sense, I understand suspension as a mode of subjectivity in which vital aspects of the self cannot be taken for granted, but rather where the continuity of a sense of "moral personhood" (Myers and Yarris 2019) is deeply at risk. Ortner (2005) reminds us that subjectivity is the basis of political agency; a suspended

subjectivity results in feelings of hopelessness and abjection, and in a sense of social defeat experienced as an ever-present risk of social death (Luhrmann 2006; Haas 2017).

Simon's experience of masculine suspension emerged clearly from his words, which he chose carefully when reflecting on his life and erectile dysfunction in Palabek, describing why he often thought of ending his own life: *"I cannot work, and I cannot perform* [sexually]. *I feel useless in this world.*" As noted by Silberschmidt, sexuality and sexual behaviours are strongly shaped by social and cultural contexts "where men and women are submitted to prescribed gender roles, norms, values and expectations" (2004:245). Echoing this, Honwana (2013) and Hunter (2005) have discussed the role of context on male sexualities, showing that challenging socio-economic circumstances often impact men's sexual behaviours. Among Acholi-speaking and other groups within Africa, erectile dysfunction is a feared condition, sometimes connected to witchcraft (Bonhomme 2012) as well as being heavily stigmatised (Kizza et al. 2012). Cosmologically, erectile dysfunction is often understood as one of the possible punishments for kiir, the breaching of a moral code related to social or cultural norms (O'Byrne 2016; Crazzolara 1938).

But even when kiir has not been committed, erectile dysfunction bears strong links to men's identities (Schulz 2018). Within contemporary Acholi heteropatriarchal societal context and norms, the ability to have sex and father children is a core component of hegemonic ideals of masculinity (Porter 2019; Dolan 2002), and men are often under great pressure to prove their virility in both these ways. Erectile dysfunction (in Acholi also often mistakenly equated to infertility) has the potential to invalidate male identities, shrouded in secrecy as it is a source of shame and often grounds for divorce – putting the social status of adult men at further risk (Schultz 2018). Simply put, adult men cannot be perceived as such when sexually impotent. The threat that erectile dysfunction poses for Acholi men is therefore hard to overstate, and deeply existential; men refer to being sexually impotent as 'not being alive' (Victor 2018; see also p'Bitek 1964), and erectile dysfunction has often been linked to male self-harm and suicide (Kizza et al. 2012; Kinyanda et al. 2005).

The experience of not being able to perform as a man – socially, by farming or having a reliable income, and sexually by performing Acholi ideals of masculine power and virilism – played a central role in Simon's 'overthinking'. In the context of the temporal dispossession which he experiences in displacement, Simon experienced his masculinity as suspended in

time, and his own personhood and identity as dangerously at risk. Temporality emerges here as one of the 'fundamental human processes' (Jenkins 2015) engaged by experiences of mental illness under conditions of structural adversity.

By deploying the lens of masculine and identity suspension, what becomes visible is that Simon's affliction was further worsened by psychiatric care in the settlement. The medication he was prescribed, and which he took for several months, did not improve his condition; in fact, it made his inability to perform as a man worse. Since taking it, Simon had been oversleeping; the sedative side-effects of AM are well known (Barnett 1988; Chen et al. 2018), and so common that Acholi women who were prescribed it in post-conflict northern Uganda referred to it as 'yat nino' – literally 'sleep medication' (Yen 2018:145). But within Acholi ideals of provider and protector masculinity, this tiredness interfered with his ability to perform the masculine role of protecting his home. *"He sleeps too much now",* his wife Rose commented during an interview, her voice just above a whisper. *"A man should not oversleep; he should be awake, to control the house and the compound. He has to be alert and responsible".*[75] As a prominent elder of the Pajok community explained: *"In the evening, men should be outside. They have to know everything that happens in their compound to defend it. As a man, you cannot go inside early.*" By interfering with his ability to perform the masculine role of protecting his home, the medication exacerbated Simon's experience of suspension of his identity as a man.

7. Temporal dispossession and mental illness in Palabek refugee settlement

Simon's story allows for an analysis of the way in which mental health professionals in Palabek settlement (mis)understood his 'overthinking' and sought to treat his affliction. The current clinical and academic literature concerned with refugee mental health is often focused on closing the so-called 'treatment-gap' – that is, on providing mental health services where they may be lacking (Thornicroft et al. 2017; Patel et al. 2011). Yet, despite having access to free and regular psychological care, Simon understood it as failing him, eventually discontinuing treatment and his visits to the Health Centre. This was a common choice among mental health patients in Palabek, who often stopped returning for follow-up visits

[75] Erectile dysfunction is another common side-effect of Simon's treatment of amitriptyline (Chen et al. 2018). While there is no way of knowing whether this was in fact the case, there is a possibility that Simon's erectile dysfunction was perpetuated, or even worsened, by the medication he was prescribed.

(see Chapter 7). Simon's and many other refugees' frustration hints at a different problem than the scarcity of available mental health service, the provision of a kind of care that not only appears inadequate, but risks being misplaced and even harmful. A temporality-informed analysis of clinical encounters in Palabek settlement shows that two factors may contribute to treatment abandonment in refugee settings: an almost exclusively psychocentric approach to psychological suffering rooted in socio-economic conditions; and a temporal disjuncture deeply embedded in the psycho-diagnostic process in humanitarian contexts.

At least six different organisations are specialised in the delivery of mental health interventions in Palabek settlement. Following the push towards the scaling up of mental health interventions in low-income and humanitarian settings (Echeverri et al. 2018), since 2018 a weekly mental health clinic has been run in Health Centres II and III in Palabek by an international NGO, contracted by UNHCR. Staff perceived this development as highly innovative; despite the increasing attention that the field of Mental and Psychosocial Support (MHPSS) in humanitarian settings has gained over the past decades (e.g., Jones and Ventevogel 2021), Uganda is one of a handful of countries that have moved so decisively towards the integration of mental health care into primary health services in humanitarian contexts.

The few psychiatric officers and nurses running the mental health clinic in Palabek refugee settlement described their work as modelled after a 'bio-psycho-social' approach. While they occasionally provided short counselling sessions to patients, however, they heavily relied on the prescription of psychotropic pills. Their practice, they explained, was informed by the 'mhGAP Intervention guide' manual (WHO 2008; see Chapter 6) – a toolkit for addressing mental health and neurological disorders in humanitarian settings, often criticised for being exceedingly rooted in Western psychiatric categories, and for carrying a high risk of medicalizing psychological distress (Gómez-Carrillo et al. 2020; Ventevogel 2014). Meanwhile, the delivery of non-biomedical mental health interventions, such as group therapies and short forms of counselling, is left to a few NGOs across the settlement.

Like most facilities in Palabek settlement, the Health Centres are structures of wooden poles, tarpaulin and iron sheets, and the heat inside would often make it hard to stand for many (especially pregnant women, many of whom preferred to sit on mats outside, chatting among

themselves). Sitting in a small room, where privacy was possible only by an iron sheet door which remained open most of the time, a psychiatric nurse (occasionally joined by a psychiatric officer) would receive dozens of patients on clinic days, their medical booklets towering on the white plastic table at which the nurse sat. Patients spoke in soft voices; many were known to the staff and were coming back to collect their treatment, like Simon when I met him, but the arrival of new patients was a frequent occurrence. The staff would collect their medical history, which the patients would convey amidst the screams of babies and the fast passage of rats across the room.

The clinical interview would inevitably end up revolving around the patient's psychopharmacological treatment: Were they taking it? Were they taking it correctly? Caregivers and family members, when present, were questioned on the same issues. Whenever a doubt arose that treatment was not being followed, medical staff, patiently but firmly, would repeat precise instructions on tablet administration. In the busy atmosphere of the clinic, where the overworked and under resourced staff attended to dozens of patients every week, and where scarcity of resources and personnel only allowed for short consultations, the prevailing attitude among the health staff was that mental health problems should be tackled through a biomedical approach. However, the centrality of psychiatric medication in the clinical practice of mental health staff in Palabek led to the obscuring of socio-economic and temporal aspects of refugees' affliction.

By the time the discussion above took place, in which Simon had described feeling like his 'head was stuck', Simon had stopped visiting the mental health clinic and had interrupted the amitriptyline treatment he had been prescribed. Weeks earlier, he had tersely explained:

> *"Those doctors, they don't listen to me. I explain and they write it down, then they give some tablet that I should swallow for two weeks. Yet you swallow the medicine and you don't find any improvement.* […] *They don't want to really help me, they just keep on adding medication."*

In many ways, he was right; while Simon had started seeking medical assistance in Palabek refugee settlement hoping to medically treat his erectile dysfunction, which he experienced as one of the main causes of his 'overthinking', the mental health workers had interpreted his erectile dysfunction as a psychosomatic manifestation of trauma, treating him accordingly.

The dispute around his symptoms had been a vital, yet silent one. Like most refugees attending the mental health clinic, Simon had been directed there by health workers at the settlement's Health Centre III, based on his symptomatology. However, he had not been clearly told why that had been the case, why he had been prescribed medication, or what the treatment was supposed to tackle. As delivery of healthcare has been noted to significantly impact people's experiences of medications, as well as outcomes of and compliance with treatment (Jenkins and Kozelka 2017), this lack of communication exacerbated Simon's experience of his affliction not being adequately addressed.

Mistrust towards the Health Centres in the settlement was not exclusive to mental health patients; rather, it was a widespread view among the vast majority of refugees, who felt that their concerns were not heard, and that healthcare providers were quick to dismiss their worries and symptoms. This contributed to a 'ecology of fear' (Das 2007) in Palabek settlement, in which health care workers and facilities were perceived by refugees as complicit in re-producing the suffering caused by the humanitarian system. The scarcity of funding available to health services also impacted healthcare provision, increasing refugees' frustration. Although medical care is provided for free in the settlement, facilities often lack common prescriptions, and patients, who often have to walk for hours to reach the facilities and endure hours-long waits, go home empty handed.

Several refugees reported being verbally abused by staff; a woman who had given birth at the Health Centre III reported being denied painkiller medication by a Ugandan doctor, who told her: *"You South Sudanese, you don't feel pain anyway"*. While these perceptions were widely shared by refugees irrespective of gender, women generally visited the Health Centres in the settlement more often than men,[76] and experienced the shortcomings of the medical humanitarian system on a regular basis. *"If you say something, they may give you medication that will kill you",* one woman said. After visiting the centre in vain for the second time in a row, she had had to buy medication for her young child elsewhere. *"You never know, maybe they will do something bad to you"* she added. Her statement, in which doctors and their activities were characterised through with the deep suspicion usually reserved for spirit

[76] Often, this happened as a part of childcare responsibilities, which among Acholi and in East Africa more generally tend to fall overwhelmingly on women.

mediums (ajwaki), hints at the powerlessness that refugees in Palabek experienced in their relationship with the humanitarian apparatus.

Often, people simply gave up on going to the Health Centres, treating their condition with local remedies, or purchasing medication – if they were able to afford it – at settlement pharmacies. James, the Ugandan owner of one of the most frequently visited pharmacies in the settlement, explained: *"Sometimes at the Health Centres, people are provoked and mistreated. But when they come here, you counsel them, and they open up. People don't just come here for treatment; they also come to talk about their problems"*. More often than not, he found that the most pressing problems involved lack of money and resources:

> *"Worries about money are related to health. Stress and worries will cause sickness to come, like heart conditions and ulcers. This is what happens when people have many thoughts. So, I try to give them advice on how to get jobs. First you support them, then you direct them"*.

He sighed: *"At the Health Centres, they do not give this kind of advice"*.

James' observations point to the impact of socio-economic conditions, and of the experience of temporal dispossession to which they contribute, on refugees' mental health. Yet, the academic and policy discussion around psychological distress in displacement rarely considers these aspects. It is widely accepted that refugees and other war-affected populations are particularly affected by mental health problems; however, the global narrative around refugees' psychological suffering still bears the influence of the widespread and pervasive "trauma discourse" (Argenti-Pillen 2013; Torre et al. 2019) that for decades has dominated MHPSS, locating refugees' "locus of suffering" (Haas 2017:77) in past traumatic events experienced during displacement, rather than in their current circumstances. In Palabek settlement, the same issue emerged from policy narratives around refugee mental health; almost invariably, trainings, workshops and official representatives' speeches on these subjects centred notions of trauma and PTSD.

Among patients visiting the mental health clinic, as well as in everyday discussions in the settlement, descriptions of psychological distress through the idiom of 'overthinking' were widespread. When asked about the roots of this condition, Acholi people overwhelmingly

described present circumstances, often summarised with the explanation: *"Kwo pe yot kany"*; Life is not easy here.[77] While many people were still greatly affected by horrifying events they had experienced during the civil war they had fled, and may well fulfil the diagnostic criteria for PTSD, cases like Simon's and many others show how much 'extraordinary conditions' of displacement and widespread worries about the future contribute to refugees' psychological suffering. While mental health workers would occasionally sympathize with patients who openly spoke of the challenges of life in Palabek settlement, and in so doing seemingly acknowledged the role of displacement in causing their patients' afflictions, this recognition was not reflected in their clinical, and particularly diagnostic, practice. Rather, the influence of trauma discourses clearly manifested in the interpretation of most forms of psychological distress, including 'overthinking', as various manifestations and consequences of past traumas. Simon's diagnostic process was a clear example. While his clinicians referred to his 'overthinking' as 'depression', they were always careful to specify that the root of the disorder was to be found in the trauma he suffered at the hands of the soldiers who tortured him. Perceiving Simon's hopelessness, the psychiatric nurse would try to counsel him: "*To be with your wife, you need to change the way you think. The moment you change the way you think and forget about the past, everything can change".*

Brun (2016) notes that the logic of the humanitarian apparatus, dominated by ideas of crisis and imminence in its operations, is characterised by an overwhelming focus on the present, failing to consider the significance of future-making. While her point is certainly relevant in Palabek, it needs to be expanded to incorporate the temporal action of psychiatric practice in displacement, which focuses on *present* symptoms to which it attributes *past* causality. In their comprehensive study of idioms of 'overthinking', Backe and colleagues describe this state as "a temporal condition, one in which an individual's ability to move through present conditions of hardship becomes immobilized" (2021:674) – similar to the phenomenological image evoked by the idea of one's head being stuck ('wii ya omoko') expressed by Simon. But in the encounter between refugees and psychiatric practice in Palabek, the present time disappeared, as did any mention of life circumstances situated outside of the patient's mind. Only the past carried weight; Simon's suspension in the present, and the dispossession of his future, remained unaddressed.

[77] Similar findings have been described in contexts both within and outside of Uganda; see e.g., Vorhölter 2019, Roberts et al. 2022.

8. Towards a temporality-informed mental health care in displacement

The choice of diagnostic label is a selective and active decision on the part of the mental health worker involved in the clinical encounter. When mental health practitioners interpret Simon's 'overthinking' as solely and directly caused by prior traumatic events in his life, they make a choice with significant medical and political consequences. By relying on presumptions about PTSD, the cause of suffering is firmly placed in Simon's past. This diagnostic choice disregards the aspects of his affliction that have to do with structural challenges and hardships that refugees face, which dispossess them of the ability to plan for a feasible and better future. The diagnosis of PTSD thus acts as a depoliticising buffer in the relationship between doctors and patients; doctors were eager to engage past traumatic events, actively probing patients on them, and encouraging them to list any 'bad thing' they may have witnessed or experience. This is partly dictated by resource constraints on the side of mental health services, whose staff do not have the capacity to address socio-economic challenges that significantly shape refugees' afflictions, as well as by the political landscape of Palabek settlement. In practice, however, this creates a temporal disjuncture between the causes of refugees' suffering and the ways in which this is diagnosed and tackled. The temporal framing of psychological suffering carries important implications for therapeutic pathways and outcomes, as well as for forms of accountability in the humanitarian landscape of Palabek settlement.

Hage (2005) notes that most disciplines studying migration seem to be unable to grasp the complexity of refugees' and forced migrants' experiences in displacement. This appears to be the case for the field of mental health and psychosocial support, which seems unable to move beyond an excessive focus on individuals' psychological traumas and increasingly medicalised forms of care in humanitarian settings. As the story of Simon's and other refugees' affliction shows, this has important implications for the ways in which refugees' suffering is understood and addressed. Otake and Tamming (2021) have argued for a reconceptualization of psychosocial healing in post-war African communities as temporality-based, recognizing the therapeutic potential of being able to imagine and project oneself in the future. These considerations strongly echo the concerns of refugees in Palabek, making a strong argument for a reconceptualization of psychological care in displacement beyond the management of psychiatric symptoms.

Rethinking mental health interventions can lead the way to a wider, and much needed, temporal turn in forced migration policy. Uganda's refugee laws enjoy an overwhelmingly positive reputation when compared to significantly more restrictive policies in the Global North, largely by granting refugees the right to work. Yet, in this article I have suggested that the freedom to work does not necessarily translate in the opportunity to plan for the future. Rather, in the absence of present stability, it can trap people in cycles of exploitation and precariousness. Refugees' temporal afflictions in Uganda carry particular significance, as they point not just to the grave fallacies of one country's migration management, but to the need of a wider reconceptualization of states of displacement.

A way forward may be found in rethinking mental health support in ways more attuned to refugees' temporal needs. This involves acknowledging the relevance of experiential categories of suspension and partially scaling down interventions addressing clinical symptoms, in favour of feasible and sustainable strategies of future-making. At a time in which advocates for mental health care in humanitarian settings call for the integration of such programmes within other components of aid delivery (see e.g., Tol et al. 2020), what is needed is a reframing of livelihood interventions as not simply sustaining life or generating income, but as carrying a fundamental therapeutic value. This proposition has complex ramifications, including redirecting flows of funding from the delivery of psycho-centric interventions to the expansion of livelihood-making ones. And yet, evidence exists for the potential of such a shift. Recent studies show that social interventions (Burgess et al. 2023) such as cash transfers (e.g., Bauer et al. 2021; Haushofer 2021) and housing assistance (e.g., Campion et al. 2022) significantly improve mental health outcomes, aptly demonstrating the significance of social determinants of mental health and the role of material resources in facilitating future-healing (Otake and Tamming 2021). By de-exceptionalising displacement (Ramsay 2020) and understanding it as a temporal condition, we open the possibility for similar interventions to be extended to refugee settings.

What this may look like in Palabek, and in other refugee settings worldwide, is an open question which will require context, culture, and gender-specific considerations. For example, while access to land emerges as vital in experiences of refugees in Palabek, this may not be the case elsewhere. It is essential that future research (and future-oriented studies in particular) explore possible scenarios in this sense, as well as the intersection of femininities,

displacement, and temporality, to create sustainable and inclusive temporal landscapes that enable refugees to reclaim their health, identities, and – crucially – their time.

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Chapter 9. ‘All in good faith?’ An ethno-historical analysis of local faith actors’ involvement in the delivery of mental health interventions in northern Uganda

Abstract

Faith actors have become increasingly significant in the field of global mental health, through their inclusion in the delivery of psychosocial support in humanitarian settings. This inclusion remains empirically underexplored. We explore historical and contemporary activities of local faith actors in responding to mental disquiet in northern Uganda. Given pre-existing roles, we question what it means when humanitarians draw on faith actors to deliver mental health and psychosocial support (MHPSS) in conflict-affected settings. We argue for a recognition of faith actors as agents operating within a therapeutic marketplace, which on occasion links suffering to social inequality and exclusion. We show, moreover, that the formal inclusion of Christian actors within MHPSS may not equate to the enforcement of rights-based values at the core of international ideas of protection.

1. Introduction

Since the 1990s, the field of humanitarian protection has undergone profound shifts. On the one hand, mental health and psychosocial support (MHPSS) interventions aimed at improving the psychological wellbeing of crisis-affected populations, have come to constitute an established branch of humanitarian assistance (Jones & Ventevogel, 2021; Tol et al., 2020). On the other hand, humanitarian policy and discourse has increasingly advocated for a move towards the localisation of the operational delivery of assistance. By virtue of the legitimacy which they often retain among their communities, local faith actors (LFAs) have become particularly significant in mediating the distribution of humanitarian assistance (Thomson, 2014; Wilkinson et al., 2022). At a time at which MHPSS interventions are burgeoning thanks to the influence of the field of global mental health, humanitarians have begun to involve LFAs in the provision of MHPSS.

Critics have pointed out that international aid often instrumentalises LFAs, imposing requirements to fit within international programmes (Ager & Ager, 2011; Jones & Petersen, 2013). As such, extensive policy and scholarship has focused on how to localise assistance (Wilkinson et al., 2019; OECD, 2017). The potential implications of faith-based alliances have been left out of humanitarians' calculations. We suggest it is important to critically consider the complex (and sometimes problematic) social processes through which LFAs become legitimate. LFAs' involvement in dealing with forms of mental suffering is far from novel, and although faith can benefit individuals' psychological wellbeing, LFAs' actions also have an important role in governing the social and moral landscapes in which they are situated, sometimes through normative and exclusionary practices.

Although a rich anthropological literature offers in-depth analyses of the socio-moral work of religious actors, this scholarship is frequently disregarded by advocates for the inclusion of LFAs in MHPSS (Ager et al., 2018). Furthermore, bound by Euro-American scripts of mental health and symptomatology of illness, humanitarians and clinicians assume accounts of possession and witchcraft to be distant from their work. However, there is a distinct overlap in such experiences for people who are the target of humanitarian aid (Whyte, 1997). By uncritically positioning LFAs as 'brokers' for the delivery of assistance, current humanitarian policies risk overlooking, and indeed facilitating, forms of violence and oppression that are well-documented in anthropological scholarship. Such a risk, which directly contradicts humanitarian mandates, makes these new alliances with humanitarian actors worthy of critical analysis.

In this article, we offer a critical analysis of the inclusion of LFAs in the delivery of mental health assistance, rooted in ethnography and historical practice. We do so not through assuming the primacy of humanitarian principles, but through examining processes on the ground. As such, we reverse the donor–recipient gaze, centring ethnographic evidence and departing from an appreciation of what role(s) LFAs already play in the field of mental health, thereby extending our reflection to what this means for humanitarian actors pushing for closer partnership with them. Specifically, we depart from extended engagement with the pre-existing everyday work of religious actors in addressing mental disquiet across conflict-affected populations across northern Uganda, a region where we have worked continuously between 2015 and 2021. Acknowledging the diversity of actors connected to faith, we follow

Wilkinson's categorisation of LFAs as ‘groups of individuals, and individual religious leaders with different levels of power and religious affiliation across local and national levels’ (2018, p. 113). Although several faiths are professed in northern Uganda, Christian actors retain by far the most widespread presence, with Muslim ones representing an historically small minority (Alava, 2017; Ward, 2001). Therefore, in this article, we focus particularly on the actions and histories of Christian faith actors.

This article begins by analysing the shifts in global humanitarian policy that push for the inclusion of LFAs in the delivery of mental health interventions. To situate LFAs within the different actors involved in healing psychological suffering in northern Uganda, we then outline the therapeutic landscape of the region, and introduce our research sites – Lamwo District, Acholiland and Arua District, West Nile. In these diverse but deeply connected spaces we explore how the actions of LFAs, involved in redrawing moral–social boundaries through cleansing possession and witchcraft, have had widespread social consequences for recipient groups. We conclude with a discussion of the implication of overlooking these activities for humanitarians.

2. Including LFAs in the delivery of mental health

Despite roots in a long history of Christian missionary efforts, and despite fundamental links to altruism and compassion, the humanitarian system is generally understood in secular terms (Barnett, 2011; Ferris, 2011). Over the past decade, however, the role of faith in humanitarian work has become the object of renewed interest, in what Wilkinson et al. (2022) call a ‘turn to religion’ among international aid actors. Scholars have argued for the recognition of religion and spirituality as central to the lives of crisis-affected groups (Ager & Ager, 2011; Wurtz & Wilkinson, 2020).

The rediscovery of the role of faith has coincided with the ‘localisation’ of aid (UNHCR, 2020; WHO, 2020; World Vision, 2020). LFAs, it is argued, are trusted and knowledgeable about their communities, positioning them as ideal humanitarian ‘brokers’ to deliver humanitarian aid (Wilkinson et al., 2019). Several ‘toolkits’ and guidelines have been produced to achieve such collaborations (French et al., 2018; Watson et al., 2020), while the United Nations High Commissioner for Refugees (UNHCR) has described LFAs’ inclusion in

humanitarian activities as a ‘journey of mutual discovery’ (UNHCR, 2013, p. 6). Although the consensus is to regard both development and religion as inherently good things (Rakodi, 2007), the existing literature tends to portray faith actors as a homogenous group, disregarding their local histories (Ferris, 2011). In addition, although much development literature invokes normative assumptions that faith actors can easily be harnessed to deliver projects, evidence of effectiveness is lacking (Olivier et al., 2015; Winiger & Peng-Keller, 2021).

Perhaps unsurprisingly, owing to the established links between psychosocial wellbeing and spirituality (Hatala & Roger, 2021; Schafer, 2010), one of the most visible entanglements of faith and aid delivery has been found in the delivery of mental health assistance. The past two decades have seen the growth of the academic and policy field of global mental health, which has emphatically advocated for an increase of efforts in delivery of psychological assistance in the Global South (Tol et al., 2020), and which has contributed to establishing clear links between mental health and development through the inclusion of the former in the UN Sustainable Development Goals (Bemme & Kirmayer, 2020; Mills, 2018; White et al., 2017). As such, MHPSS has been established as a mainstream component of humanitarian aid worldwide (Jones & Ventevogel, 2021).

MHPSS practitioners have long advocated for the formal inclusion of religious actors in the delivery of psychological assistance (e.g., IASC, 2008).[1] A growing clinical and academic literature argues for the need of faith-sensitive MHPSS and for establishing collaborations with LFAs (Ager et al., 2018; Harsch et al., 2021; Rutledge et al., 2021; Trotta & Wilkinson, 2019). Faith-based organisations, including the Lutheran World Federation, World Vision and Islamic Relief, have increasingly started offering mental health services and lay mental health techniques such as psychological first aid and psychological counselling trainings to religious leaders (Featherstone, 2015; Türk et al., 2014; World Vision, 2020). In northern Uganda, several mental health programmes are already delivered by faith leaders (Ager et al., 2014).

A large body of anthropological literature has examined in-depth the work of religious actors in social healing (i.e., Behrend, 2011; Mogensen, 2002; Vokes, 2013). This literature tends to be side-lined by humanitarian actors, yet attentive consideration of the anthropological evidence detailing faith actors’ deep historical engagement with local social fabrics provides an extensive repertoire to think through their involvement in humanitarian mental health

provision. Based on our ethnographic work in northern Uganda, we seek to analyse and extend this evidence base focusing on the pre-existing work of LFAs.

We ask: What does it mean to build collaborations with LFAs who have pre-existing social roles and relationships in communities of interest to humanitarian workers? What are humanitarians legitimating through engaging with LFAs? To answer these questions, we depart not from preconceived ideas of how assistance should work, but from understanding pre-existing approaches to manage psychological suffering in conflict-affected spaces (Macdonald & Allen, 2015). In what follows, we consider therefore joint histories of trauma management and LFAs' work in dealing with psychological distress in northern Uganda.

3. Researching trauma healing in northern Uganda

A region with a deep history of conflict, as well as both internal and cross-border displacement, northern Uganda has long served as a testing ground for new forms of delivery of humanitarian and development assistance. Such interventions have frequently been abstracted from the social context in which they inevitably become entangled.

Recent upheavals have coincided with rising donor-interest in psychosocial suffering, and northern Uganda has become a case study par excellence for the management of post-conflict trauma. Multiple studies have analysed the after-effects of the Lord's Resistance Army (LRA) bush war (1986–2006), which was characterised by extensive violence, displacement and abduction (Dolan, 2009; Finnström, 2008). The aftermath of war was characterised by extreme psychosocial suffering, manifesting in high rates of trauma and depression (Annan et al., 2011; Roberts et al., 2008), alcoholism (Mehus et al., 2021; Meinert & Whyte, 2020), domestic and sexual violence (Baines & Rosenoff Gauvin, 2014; Porter, 2016), spiritual problems (Meinert & Whyte, 2017) and alarming rates of poverty (Owori, 2020). A widespread 'trauma discourse' (Argenti-Pillen, 2000) provided a moral and financial rationale for the implementation of countless humanitarian mental health interventions targeting pot-traumatic stress disorder and depression in Acholiland (Torre et al., 2019).

The types of therapy assumed to constitute post-conflict healing have been numerous and diverse. In part, this presentation of diversity spans from epistemological and evidentiary

divides within academic disciplines. Csordas (2021) notes the disconnect between the evidence-based psychiatric approaches of global mental health and anthropological perspectives grounded in local vernaculars and experiences. Despite well-noted divergences, firmly rooted in Western psychiatric frameworks, interventions established a direct correspondence between forms of mental and spiritual affliction suffered in the region and psychiatric labels. A large cluster of studies focused on the translation of Acholi experiences into Western clinical terms (Harnisch & Pfeiffer, 2018; Neuner et al., 2012).

Yet, medical anthropologists have frequently questioned the transferability and ethics of exporting Western interventions into non-Euro-American contexts (Bemme & Kirmayer, 2020; Kienzler, 2008; Summerfield, 2012). Wary of the risks, healing has been studied with reference to local cosmological worlds, rather than to clinical diagnoses. Perhaps intentionally writing out the impacts of humanitarian presence, anthropological studies have tended to focus on the hybrid tapestry of local actors (elders, diviners and faith actors) who have attended to trauma through sociocultural processes to assuage distress. Owing in part to the metaphysical aspects of the war in Acholiland, including the LRA's intentional strategy of forcing recruits to conduct violent, spiritually polluting acts, anthropological research has often focused on the management of hauntings known traditionally in Acholi as cen, a form of spiritual disturbance often understood to bring madness (apoya) (Meinert & Whyte, 2017; Victor & Porter, 2017; Williams, 2021).

Studies of this nature have made relevant contributions to the current research. First, ethnographies have shifted from an analysis of discrete interventions (in clinical or religious settings) to highlight the processes through which individuals heal. Managing trauma is revealed to be a social conversation, or a 'therapy pathway', in which people follow the cause of disquiet and seek remedy in homes and communities, as well as in treatment settings (Victor & Porter, 2017). Second, ethnographers have highlighted that therapy options are structured by market competitions: Hilhorst and Jansen (2010) have described these options as an arena, and Williams and Schulz (2021) have referred to northern Uganda as a 'marketplace of post-conflict assistance'. Third, participation in this marketplace, particularly when flows of finance become involved, changes the legitimacy of therapy and actors (Komujuni & Büscher, 2020). Indeed, Allen reminds us that the internal dynamics of healing competition predate colonial rule (1991).

These studies include LFAs as one actor among many. Despite a few notable exceptions (e.g., Alava, 2022), studies on faith tend to emphasise the individuated aspects of interventions that resemble Western therapies (Williams & Meinert, 2020). Constrained by time, most studies have focused on a single church or religious group, and few inquiries have examined individual therapeutic outcomes in conversation with their wider social, moral and political actions. Inspired by the approach that recognises contestations within healing arenas, we reflect on LFAs' pre-existing social dynamics, and the unintended consequences of their reinforcement through humanitarian alliances.

3.1 Our connected research sites

We draw on ethnographic data collected through interviews, focus groups, observations and informal conversations between 2016 and 2018 in Arua District, West Nile sub-region, and between 2018 and 2020 in Palabek refugee settlement, Lamwo District, Acholiland.

These sites provide fruitful contexts within which to examine the implications of humanitarians' recent alliances with LFAs. In Lamwo, we explore alliances that form out of the involvement of LFAs in delivering MHPSS in Palabek refugee settlement, currently home to over 68,000 predominantly Acholi-speaking refugees from South Sudan. In Arua, we draw on the everyday work of LFAs in attending to mental disturbances in Lugbara-speaking communities living near the border of the Democratic Republic of Congo. These groups have been of interest to scholars of humanitarianism for several decades, precisely because of the absence of humanitarian intervention and the improvisation of local solutions (Crisp, 1986).

Humanitarian interventions: An expanding therapeutic marketplace?

To the mental health professional, treatment options in Arua and Palabek look very different. Despite being classified as a peaceable, 'post-conflict' space, in Arua Town and the wider sub-region mental health services have achieved relatively limited penetration; here, LFAs and 'traditional' actors dominate the healing marketplace. In this sense, West Nile resembles wider Uganda, which, with fewer than 1 psychiatrist per 100,000 people, is among the least-equipped countries in the world when it comes to mental healthcare (WHO, 2017). In 2018, a single psychiatrist worked at the psychiatric unit within Arua's main hospital, which serves the entire West Nile sub-region. Of those admitted, he estimated that 75% discharged themselves prior to completing treatment, instead 'going home' to consult herbalists and

other religious specialists. Faith features highly in Aruans' pragmatic management of mental affliction.

By contrast, Palabek refugee settlement, founded in 2017 to shelter people fleeing the resurgence of conflict in South Sudan, serves as a spatial expression of recent shifts in humanitarian policy (Torre, 2021). Various non-governmental organisations implement mental health and psychosocial interventions, and psychiatric nurses and officers operate daily within the primary clinics in the settlement.

Such attempts at establishing mental health caregivers as legitimate were often not enough to convince patients to rely on them: 'When it comes to mental illness, we are people's last choice … they will try everything else before they come to us', one mental health specialist explained. Refugees in Palabek seemed to seek the advice of mental health professionals only in rare cases, often only if explicitly referred to them by humanitarians. As in Arua, in Palabek refugees did what they had done before encountering humanitarian mental health interventions; they either turned to the church, which here too retains a huge presence in the management of various forms of mental distress, or they consulted traditional healers. Across both sites, faith-based interventions held more resonance than MHPSS.

3.2 Christian legacies and convergences in West Nile and Acholiland

Both Arua and Palabek share important Christian legacies. Populations were first exposed to Christianity through aggressive European evangelism spanning the late 19th to early 20th centuries (O'Byrne, 2017; Storer et al., 2017). Throughout the late colonial period, a faith associated with urban elites gradually spread over parts of the countryside, assisted by the arrival of the East African Revival from the late 1940s, which encouraged worship in African languages and styles (Lloyd, n.d.; Wild-Wood, 2010). Resistance remained, in part because of faith actors' disavowal of ancestor veneration.

Post-independence in 1962, war catalysed rates of Christian conversion. During post-Amin reprisals in West Nile from 1979, the ongoing war in South Sudan and the LRA bush war in Acholiland, Christian leaders played significant roles in materially and spiritually protecting populations. The centrality of LFAs in providing war-time support, accounts for their

legitimacy as arbiters of psychological after-effects. Repeating the activities of West Nilers' exile in Congo, Christian clergy in Palabek now offer support to a new generation of refugees suffering displacement. Since the 1990s, Charismatic Catholic and Pentecostal churches have appeared across Uganda and South Sudan, spreading from towns to rural areas. Movements have been fuelled both by interdenominational competition and by an acceptance of healing gifts. These movements have further amplified competition in the marketplace for healing.

In this context, we thus find deep continuities between the Christianisation of scripts of mental affliction in South Sudan and northern Uganda. O'Byrne's (2017) ethnographic study of South Sudanese Acholi people in Pajok, prior to their displacement to Uganda in 2017, provides an extensive portrait of the work of independent churches in managing possession and other health crises. This study echoes the forms of spiritual cleansing documented by Storer in Arua and by Torre in Palabek. Although according to humanitarian classifications populations would occupy different stages of a conflict/post-conflict continuum, options for managing mental distress are markedly similar. We now turn to an exploration of contemporary and historical interventions.

3.3 Social therapies: LFAs' work in managing mental disquiet

Across our research sites, LFAs from both the Anglican and Catholic faiths were continually involved in the management of manifestations of mental disquiet. Rather than invoke Western vernaculars, in both Arua and Palabek mental suffering was often translated as a lack of peace, 'overthinking', sadness, 'madness', receiving revelations, hearing voices, body weakness, night terrors and visions, or possession-like episodes.

Across northern Uganda, mental health is rarely defined symptomatically, but is rather defined with reference to the social context surrounding individual cases. Discerning the root cause in a web of potentialities plays a fundamental part in the process of healing. Though the techniques within the process often involved a significant amount of improvisation, Lugbara and Acholi people suffering mental disquiet regularly sought counselling from LFAs who were either local pastors or more distant leaders reputed to have healing hands and prayers. Counselling sessions were often one-to-one, with some religious institutions offering designated times for weekly counselling. Most who sought counselling did so over periods of

weeks and months. If after that time the problem was not deemed to be 'solved', alternative specialists were sought.

In cases of ongoing mental distress, collective attention or 'home prayers' were called. Here, either members of a sufferer's 'home' congregation or more itinerant charismatic factions were sought to pray for the afflicted. With the severity of the cases grew the importance of identifying the root cause of the distress, and in many cases, LFAs would sift through potential causes with the sufferer and their family members. In the Catholic tradition, this was sometimes done through a 'Family Tree Healing' technique, where families gathered to pray and 'dig' for the root cause of suffering (Storer, 2021). Important to note is that this process was not performed exclusively for – but often included – persistent cases of mental disquiet. After several self-led sessions, a Charismatic Catholic or Pentecostal priest led a group session aimed to reveal the cause of suffering.

Depending on the persuasion of the prayer group, these performances could become ecstatic, involve the laying-on of hands or feature visions that revealed the causes of suffering. In more extreme cases, where a sufferer's symptoms included possession, name calling, falling into a trance or where their activities potentially posed harm to families or wider communities, a more urgent intervention resembling what would be termed an 'exorcism' in the European vernacular, was sought. Often, the encounter was dramatic, involving the LFA 'casting' out demonic forces in the name of Jesus or the Holy Spirit. The sufferer would roll, cry and/or shout, indicative of the spiritual battle between evil and good spirits. Although exorcisms were often performed in people's homes, owing to recent demand a priest at a popular Catholic healing centre in Arua delivered hundreds of people each week.

At the individual level, it would be possible to find examples of patients who experienced relief from these sorts of interventions, although for many this required several sessions. It is possible to draw equivalent conclusions as other medical anthropologists who have found prayer and religious healing to be a cathartic process for relieving trauma (Frank & Frank, 1993; Luhrmann, 2012; Williams, 2021). One could, too, draw parallels between the therapeutic methods of psychiatrists, who take family histories to reveal genetic predispositions to forms of mental illness. As one Anglican reverend explained, in a way that closely resembled a clinical psychiatric narrative: 'When people think they are possessed by a demon, they explain their symptoms – usually hallucinations, of course in the church the

vision is a common thing … We treat them, evaluate them further, realise the cause, and control the hallucinations.' Although processes can be individualised, the therapeutic process is often geared to revealing the social causes of distress. As is the case for many alternative healers, mimicking biomedical procedure and systematising diagnoses provides a means to legitimise spiritual interventions.

Returning, however, to the current debates in humanitarian circles, we contend that the impact of LFAs' actions on mental distress goes far beyond an individual dimension. Indeed, the diagnoses of LFAs frequently tied symptoms to the social fabric, often ascribing mental disturbances to unbalanced social relations. For example, cases of possession were often linked to bewitching, brought on by tense social relations within the sufferer's social world. In doing so, LFAs reiterate longer histories, whereby their presence has transformed the management of mental distress. Colonial records report the increasing nature of possession and 'madness' throughout British rule (p'Bitek, 1964). During this time, fierce struggles over the management of such cases ensued, whereby the interventions of diviners were increasingly displaced by LFAs. Today, Christian actors have the monopoly on managing this type of affliction, and now compete not with traditional religions, but with each other in therapeutic marketplaces (Verginer & Juen, 2019).

Indeed, in Uganda and beyond, the histories of imposing Christianity are entangled with transformation both in the concepts and the management of mental health. Through the engagement of LFAs in managing possession and other local expressions of mental disquiet, mental conditions were pulled into the social diagnostic realm (Verginer & Juen, 2019). Rather than being linked to amoral spirits in the wild, illness increasingly became attributed to harm caused by family, clan or proximate neighbours, as well as by social practices that deviated from religious directives. Indeed, these histories of entanglement are present even in local languages. For example, in Lugbarati madness (zizaru) is derived from ziza, the term that now denotes Christian prayer. Because their action established direct links between causes of mental illness and Christian moral codes, therefore, LFAs must be understood as social healers, opening up the diagnosis of mental disquiet to social malevolence in ways that female diviners either cannot or would not, since this realm of blame often proves risky for individual therapists (Storer, 2021).

However, LFAs' establishment of moral boundaries often involves perpetuating forms of violence and exclusion, which a narrow focus on individual impacts risks overlooking. In what follows, we present empirical findings highlighting two realms in which this is particularly prevalent, and encourage humanitarian workers to remain keenly aware of these aspects while relying on LFAs as brokers for localisation agendas.

3.4 Gendered divisions in therapy

As noted above, in northern Uganda manifestations of mental illness that LFAs have become involved in managing often included forms of spirit possession. However, this work has distinct effects across genders, which deserve to be kept in mind by humanitarian policy that seeks as well to diminish gender-based violence. Across northern Uganda, since possession manifests most commonly in women, and often in individuals suffering from social ostracisation, ethnographers have interpreted it as a manifestation of gendered expressions of power (Allen, 1991; Finnström, 2009; Middleton, 1960). The expression of possession has come to be understood as a reflection of the structural marginality that women face in deeply patriarchal contexts, where gendered norms have been vigorously reasserted following war (Baines & Rosenoff Gauvin, 2014).

Accordingly, in northern Uganda the reliance on Christian leaders to treat cases of possession is most prevalent among women and, latterly, other marginalised social groups (Storer, 2021). While in part, this reflects the actual incidents of possession, it also reflects sufferers' financial options – those who consulted LFAs often lacked funds for transport and/or clinical therapy, or for purchasing an animal to appease elders and attend to illness through customary pathways. Moreover, patriarchal norms often dictate the uneven distribution of resources within homes, with women lacking access to funds for alternative care options. Increasingly, men leave women altogether – and with traditional marriage rites often undone, women cannot turn to their extended relatives for help (Baines & Rosenoff Gauvin, 2014).

Crucially, those women who visited LFAs often experienced possession symptoms alongside domestic violence or extreme poverty. Yet oftentimes, the explanations for suffering given by LFAs linked mental disquiet not to structural determinants of health, but to suffering due to a spirit, demon or witchcraft practised by a proximate associate. In all instances, mental disquiet was linked to sociocultural idioms of distress that focused on a sufferer's actions, or

their close relations with others. For example, one married woman in Arua explained: ‘I entered the charismatic through the persecutions in my home. I was suffering from so many domestic problems. There were so many sicknesses in my home … When I entered this association, the lord gave me the gift through the holy spirit – that sickness stopped in the home.’

Things were similar in Palabek, where the case of Aber's possession illustrates the gendered asymmetries that can arise within LFAs’ interventions. In early 2019 Aber's husband abandoned her and her two children in the settlement, presumably to go back to South Sudan. Generally good-humoured and well-liked by her neighbours, she started drinking. During the day, she often wandered drunk through her block; rumours spread that men had been visiting Aber at night, which was understood by her neighbours as indicative of her moral dissolution. Soon afterwards, she started experiencing violent spirit possessions. In these cases, despite the fact that she was not a regular churchgoer, neighbours and members of the nearby Anglican church gathered to perform ‘home prayers’. This entailed sitting or standing around Aber, who was made to lie down outside on a mat, and emphatically praying with their hands hanging over or directly touching her body, shouting and ordering the devil to leave her.

The second time Aber became possessed, in a particularly violent episode witnessed by Torre in May 2019, she was transported to the local church where the prayer continued with the help of the pastor. When asked a couple of days later why she thought this was happening to her, still shaken up and suffering from muscle pain from the strain that the possession had put on her body, Aber said she was not sure. However, she added, she had been ‘overthinking’ – a common idiom for mental distress in Palabek – since her husband abandoned her. Because he had left her with nothing, she struggled to rely on the scarce humanitarian assistance alone.

The church members’ explanations were quite different, and focused on Aber's individual behaviour rather than on the external circumstances that she felt had deeply impact her life: ‘If you drink alcohol, the cen will not go away; the devil also likes alcohol’, one of her neighbours said. One pastor from the congregation that had been praying for her commented that she had brought her issues on herself: ‘You need to keep your door closed to the devil at all times. But if you drink, and have sex with different men, you are opening the door to it.’ Although previously she could often be found sitting and chatting at someone's home, after

this second episode things seemed to change. Aber seldom left her compound, drinking frequently and growing more isolated as her neighbours also stopped visiting her.

The narrative upheld by the pastor that dealt with Aber's case placed the blame for the suffering she was experiencing entirely upon herself. Yet the stigma around her situation promoted by LFAs' explanations resulted in her increased isolation, causing her mental health to deteriorate significantly. Often, faith actors invoke explanations that write out both past and present violence, to instead place the onus on the individual themselves or their associates (Tankink, 2007). Especially in normative and patriarchal societies, women are particularly affected by the consequences of these healing models, because the structural determinants of their psychological suffering are consistently erased from view in the work of LFAs. Rather than link violence or abandonment to mental affliction, within churches causes for suffering are often found in individuals' own behaviours, and solutions in offering forgiveness and the reformation of social conduct. Aber's case – which was managed in the community, rather than through consulting mental health services – shows the extent to which the work of faith actors is embedded in, and indeed reinforces, wider structures of power that delegitimise the suffering of those more likely to be negatively affected by them. This case, embedded as it was with social norms and expectations, was managed in the same geographical arena where advocates of MHPSS – and often the same faith actors involved – were pushing for individuated norms associated with mental health interventions.

3.5 Excluding 'others' in healing marketplaces

The everyday work of social and moral boundary-making, whereby LFAs associate possession with others, is also layered with more complex forms of othering and exclusion. Although LFAs may be conversant in multiple vernaculars of mental health, often, individuals position themselves as social arbiters, dictating the right way to heal in therapeutic marketplaces though the exclusion of other therapists. To understand this, it is important to consider the therapeutic marketplace, and social conversations about faith and healing that present seeking care from LFAs as godly, and condemn other specialists as 'witchdoctors'. This too is a term with a colonial history, introduced by missionaries to – at various junctures – condemn all non-Christian healers including prophets, diviners, elders, herbalists and latterly Pentecostal preachers. The vociferous nature of these campaigns to criminalise particular forms of healing cannot be understated – throughout the research

period, the subject was continually referenced by faith, government and health authorities during sermons, over the radio, and in the local and national news. Although quests to dictate the way to heal may be well-meaning within faith-based ontologies, such exercises often hold potential for social exclusion.

To appreciate the nature of this exclusion, it is important to note that in northern Uganda, Christian conversion and allegiance has often been premised on denouncing 'other' religious practices. During Protectorate rule, European missionaries presented Christianity as an antithesis to ancestral 'worship'. Although the veneration of ancestors was, in fact, connected to healing and the maintenance of social boundaries, fluid cultural practices were described as 'pagan' and 'satanic'. In the early independence periods, educated Lugbara and Acholi converts, as well as Revivalists, were often involved in the destruction of ancestral shrines, resulting on occasion in violent resistance. Wars and exile – when elders where distanced from the shrines – effectively brought an end to the uncontested legitimacy of ancestors within concepts of healing. The significance of this shift cannot be overlooked: it is into the space that elders once occupied, dissolved through the gradual destruction of shrines, that Christian actors have defined themselves as moral authorities able to manage suffering. As is the case with possession, where Christian actors replaced the secret work of diviners, here too, LFAs have socialised lineage healing.

Yet war and displacement saw the abandonment of shrines. Since the 1980s, LFAs in Arua have found new 'others' against which to measure the faith of believers and from whose forms of 'evil' to offer protection. Initially, this reaction was against 'witches' who were often traders who had prospered from cross-border commerce during war, reportedly from acquiring 'underwater' power. One elderly lady who had returned to Arua from Congo explained, '[Though] there were now people prophesying against witchcraft and going under the water.' Split between Christian logics of good and evil, the same marketplace that governs healing interventions is also believed to offer opportunities for harm.

Accordingly, new interventions have emerged to manage these threats. Eloquently described by Behrend (2011) in Tooro (Western Uganda), the participation of Charismatic Catholics in cleansing new forms of witchcraft through prayers and exorcism during the past decade, constructed the very world it described through its attention to producing evidentiary claims. Across northern Uganda, in contexts of repeated physical and mental suffering for which

witchcraft (or a witch) is deemed responsible, Christians decamp to a village to pray and cleanse the area. Increasingly, these groups were responding to outbreaks of possession among women and school children, and sometimes among young men (Victor, 2019). Prayers could last up to a week, and Christians often received revelations of the cause of affliction, or extracted evidence – herbs, hair, bottles – to prove evil was at work in these villages. Although such purges were greeted with natural scepticism and sometimes involved exclusion, LFA-led interventions were often deemed to keep the peace. To use Porter's terms, though these events carried the potential for exclusion, they were conceived as an important aspect of 'social harmony' (2016, p. i).

During our more recent fieldwork in Palabek, similar forms of exclusion were being perpetuated – not against strangers but against witchcraft. In the context of the anonymity of displacement camps it was anonymous healers, rather than villagers, who were associated with the threat of witchcraft. Such fears of witchdoctors made sense in the context of increasingly commercialised healing markets in Arua, Gulu and refugee settlements. The presence of these specialists was widely advertised on billboards, banners on homes and leaflets, offering cures for physical and mental afflictions, relationship problems or male impotency. Yet although the number of outsiders publicly engaging in healing has increased, Christian condemnation of witchdoctors has certainly – even ironically – raised their profile, creating a 'moral panic' (Allen, 2015) around the effects of their unverified services. Not infrequently, LFAs use the pulpit of church services to portray witchdoctors as the local personification of devil work. Their power is said to come from worshipping 'idols', rather than channelling godly forces (as faith actors do).

This condemnation has evolved into a sphere of public action against witchdoctors, now defined as a public health threat. In Arua, churches have formed new alliances with government actors and public health officials to cleanse the city of occult specialists. LFAs have been key instigators of 'raids' on witchdoctors' homes, are deemed to have spiritual authority to destroy their 'shrines', and on occasion, have expelled them altogether (Storer, 2021). Importantly, these events create the public evidence of the evil that they describe, in the production of extensive paraphernalia – snakes, bones and wild animals—all emblems of evil. One event in 2016 that followed an outbreak of disease and fire in an urban slum, Oli, near Arua, reportedly resulted in the purge of more than 370 witchdoctors from their homes (Draku & Uganda Radio Network (URN), 2016). Similar events unfolded in Arua during

2018 (Amandu, 2018). A further significant turn is that, since this time, renowned Anglican leaders had recently begun working with the psychiatric unit at Arua Hospital, to spread word of the treatments among their congregation, as well as coming to the unit to pray with patients (Verginer & Juen, 2019). It seemed this formal inclusion within the health sector seemed to embolden social cleansing activities and bolster their personal legitimacy. These events in Arua offer a caution as to the exclusion that can result when faith actors' spiritual claims become entangled with health advocacy.

As noted above, mental health professionals in the Palabek refugee settlement continuously struggled to establish themselves as legitimate actors in the local therapeutic marketplace. Formally, this difficulty was attributed by humanitarians to the 'poor mental health literacy' of the refugee population. Accordingly, psycho-education sessions took place at the main hospital in Palabek several times a week, to teach refugees about what the resident mental health nurse referred to as: 'those [illnesses] that are disturbing your thoughts or your mind'. Yet, according to clinical staff these interventions seemed to do little to improve refugees' reticence to consult the mental health clinic.

Although this reticence could stem in part from the limited relevance of Western concepts and treatments of mental illness in a setting like a refugee settlement, mental health practitioners in Palabek considered witchdoctors to be the cause of this lack of adherence to their programmes: 'We lose so many patients to witchdoctors. When they find that the treatment has not been working, you find they disappear. That means they have "gone home" to treat the issue', a psychiatric officer explained in frustration. Large portions of the sessions were thus dedicated to dissuading people from consulting witchdoctors when experiencing symptoms of mental illness. Bringing people to a witchdoctor, the same officer explained to refugees, was dangerous: 'Those rituals can be harmful; some will cut people's skin, smear herbs on them using their bare hands and expose the person to infections or to pain that can expose the patient to new symptoms and create more complications.' Several times, the nurse pleaded as well that: 'If someone has those problems, bring them to the church, or tell them to come to the hospital, where there is a medication for that'. After listening to one such psycho-education session while waiting to see a doctor himself, a Christian pastor enthusiastically commented that he would immediately tell his congregants about the mental health clinic: 'This way,' he added, 'they may go to the hospital when they are mentally ill, instead of to witchdoctors'. The management of mental health was thus brought into a

complex marketplace, where LFAs used their legitimacy to disavow other healing specialists; to embed MPHSS, LFAs directly sought to cleanse communities of witchdoctors.

In Palabek, these community outreaches were as much an educational tool as they were an effort by humanitarian mental health workers to construct themselves as legitimate and trustworthy therapeutic actors in the eyes of the refugee population. To do this, psychiatric staff in Palabek chose to rely on the establishment of an explicit alliance between LFAs and humanitarian ones, in strong opposition to witchdoctors and other 'traditional' actors. In these speeches, mental health professionals therefore equated churches and hospitals with moral forces for good, and witchdoctors with forces for evil. The concern advanced by this research, however, is that historical evidence indicates that in contexts of affliction and death, castigations of witchdoctors have often turned into violent purges (Allen, 1991; Harrell-Bond, 1986). Our evidence suggest that these risks are magnified by novel and uncritical reliance by the humanitarian system on LFAs to deliver mental health.

4. Discussion

When the humanitarian apparatus chooses to rely on faith-based actors, it chooses to do so for reasons related to facilitating its operations on the ground. The logic of convenience behind this choice is easy to grasp: seeking the support of individuals and institutions that retain legitimacy among the local population is in many ways a sensible antidote for the diffidence that humanitarians may experience, either towards themselves as external actors or towards the programmes they implement. Certainly, this choice is well-intentioned, and emerges from an awareness of longstanding and ongoing debates regarding the problematics of imposing externally defined priorities without local buy-in.

Yet our evidence shows that humanitarianism's engagement with LFAs frequently overlooks essential aspects of their social role in the communities where they exist and operate. Indeed, we have found it is precisely these historical engagements, such as those in attending to mental disquiet that have rendered faith actors able to act as intermediaries or 'brokers' between humanitarians and local populations, that are written out of policy calculations. Indeed, we contend that the prior social embeddedness of longstanding therapeutic

engagement can in fact serve as significant barriers to instilling humanitarian visions of rights-based protections.

Based on our extended engagement in fields of healing in Arua and Palabek, we have shown how the management of mental affliction results from long processes, whereby Christianity was legitimised through proving the impotence of ancestors and diviners. It is significant, moreover, that these struggles have been emboldened because pastors and priests have long served as local anchors for international partnerships – secular and spiritual – with European and American churches, as well as with donor agencies. But on the ground, legitimacy has become entangled with entrenching – and reshaping – particular vernaculars of affliction, both mental and physical. Although these struggles may seem entirely remote to mental health professionals in Euro-American contexts, they have been replicated over many African (and other) contexts.

In contemporary times, we have shown how struggles over legitimacy include competition with biomedicine, and we have suggested that exclusionary practices connected to faith healing tend to be legitimated when external actors formally include faith actors in the delivery of health (as biomedically defined). Struggles in therapeutic marketplaces are always evolving – the arrival of, for instance Pentecostal and transnational fundamentalist Christian movements – which inevitably shift the contours of competition and local debate. We have located our findings within the wealth of anthropological literature, which has urged that Christianity specifically and faith generally be considered not as an abstract institution, but as a set of ideas and practices that are constantly enculturated into the moral, social and spiritual world of believers (Allen, 1991; Behrend, 2011; Wild-Wood, 2010). We thus urge a reconsideration of LFAs' longstanding roles as both mediators and shapers of hybrid socio-spiritual worldviews, and as interested parties in healing marketplaces. This reconsideration has particular implications for their reiteration of normative patriarchal views entrenched through healing practices. As Tyszler notes with reference to the intersection of religious and humanitarian intervention in Morocco, religious actors often operate in ways aimed at 'preserving exemplary moral standards of femininity' (2019, p. 60). Here, too, their entanglement with humanitarian actors reinforces oppressive patriarchal structures already in place.

As recent studies have shown, the cleansing of post-conflict trauma and other forms of psychological suffering remains an arena within which social and resource struggles play out. Thus, although much research on northern Uganda reveals contests between epistemological stances, the clustering of studies around particular concepts, actors and places leaves many other realities unanswered. In particular, studies that focus on patient pathways, a single healer or church congregation, tend to remove the social context from interventions. Yet we argue that the social context within which therapies are delivered is essential to understanding individual recovery, as well as the inadvertent effects of novel alliances in delivering therapies.

Significantly, it is striking how the positive visions of faith-based healing (e.g., Ager et al., 2018; Harsch et al., 2021; Williams, 2021) stand in tension with ethnographic work that has highlighted the challenges of rebuilding communities after crisis. Prospects of rebuilding lives are deeply gendered – although women may be empowered in church services, once those services have ended – they may well face difficulties accessing recognition within normative clan-based structures. As Porter's (2016) study of Acholi women's attempts (or not) to seek redress for rape powerfully elucidates, visions of social harmony are both inclusionary and exclusionary. Scholars have kept largely silent on the management of witchcraft, yet it is the very same therapists governing social evictions who manage supposedly restorative spiritual cleansing. Critically, as others have argued (Allen, 1991; O'Byrne, 2017), these processes represent another face of reconstruction. Our evidence, in conversation with the rich anthropological literature that has emphasised the frictions between different actors with competing visions of social repair (Macdonald, 2017; Storer et al., 2017; Victor & Porter, 2017), suggests that these collective social processes equally link to mental health agendas in surprising ways.

Although we acknowledge the fundamental role of faith and religious communities in contributing to psychological wellbeing, we argue that the aspects of exclusion and reproduction of structural oppression that are inherent to the work of LFAs warrant concern. As the difficulties of localising external priorities for aid become apparent, scholars have often urged that the pre-existing attachments of local actors who serve as humanitarian partners be considered (Abramowitz & Kleinman, 2008). It seems surprising that the enthusiasm for faith actors persists even as scholars and activists campaign for a recognition of the exclusion practised within customary authorities (Quinn, 2022), as well as the violent

roots of Christian imposition from the colonial period (Benthall, 2017). We suggest that it is only by engaging in this complexity that realistic dialogue can begin between actors to promote forms of mental health support that respect individual rights and dignity.

5. Concluding remarks

Contemporary humanitarians advocate for a global mental health movement premised on human rights, individuated treatment and a recognition of the structural determinants of mental distress. Pursuing this laudable aim, it is assumed that local actors are conversant and invested in Western notions of mental health. Yet by neglecting the complex and fraught therapeutic landscape of northern Uganda, flows of humanitarian resources directed at LFAs may risk overlooking the intricate histories, relationships and agendas of these actors. Considering these factors and complexities, we caution against the recent enthusiasm that sees enormous potential in training and relying on LFAs to deliver mental health assistance.

In societies where identity is relational, and managing affliction has long involved relating symptoms to the activities of others, LFAs' interventions are likely to be pulled into deeply embedded exercises to redefine social boundaries. Indeed, it is this deep historical involvement – borne through local populations' navigation of colonial violence and post-conflict upheavals – that has rendered many LFAs legitimate arbiters to determine the cause of affliction. We suggest these activities cannot simply be ignored in favour of developing toolkits to instrumentalise imported concepts of mental health, but rather should constitute an important starting point to consider localising aid.

When social dynamics and longstanding histories of managing affliction are side-lined in humanitarian work, caution is warranted. Such interventions may exacerbate struggles for legitimacy in therapeutic marketplaces, where a variety of Anglican, Catholic, Pentecostal and other actors compete both among themselves and with traditional healers. At the centre of such struggles lies the management of mental disquiet, and, if these risks go unheeded, the potential for profound exclusion for sufferers.

Chapter 10. Concluding thoughts

1. The arguments revisited

By presenting ethnographic evidence from fieldwork conducted in the refugee settlement of Palabek, this thesis has offered an analysis of Acholi refugees' experiences of displacement in Uganda, of the role of socio-economic factors and of the shortcomings of the humanitarian response on their mental health, and of the political nature and implications of mental health interventions in complex emergencies. It has argued for the pivotal role of contextual factors, such as socio-economic, political, and structural circumstances, in shaping refugees' experiences of affliction in displacement, as well as their experiences of mental health interventions and their efficacy. It has shown the interrelation of contextual elements with the social, clinical, and political lives of psychosocial interventions in Palabek, through a variety of epistemological and scalar perspectives. These interrelations are multiple, and manifest differently at various levels of analysis. The main points of this thesis can be summarised as follows.

First, humanitarian psychosocial interventions are not neutral and apolitical actors in the contexts in which they are introduced, but rather intersect with and are shaped by local political dynamics. These findings are in conversation with historical and ethnographic literature which has analysed the "super-structure" of psychosocial programmes (Abramowitz 2014:5) and their entanglement with political agendas (e.g., Abramowitz 2014; Ibrahim 2021; Pupavac 2005; Pillen 2000). In Uganda, psychosocial interventions become means of governmentality aimed at the construction of 'entrepreneurship-oriented subjectivities', able to withstand risk and to achieve self-reliance (Chapter 4). Here, global neoliberal political and developmental agendas shape the 'psy' complex – that is, the assemblage of mental health discourses and practices circulating in Palabek settlement – by increasingly orienting the knowledge and interventions of which it is comprised towards individualised and psychocentric models of mental illness. In so doing, these interventions mask the failures of the humanitarian system, protecting the country's reputation as a progressive refugee host, and at least partly shielding humanitarian organisations, aid workers, and high-ranking individuals from allegations of negligence and corruption (Chapter 5).

The second main point that this thesis has put forward concerns refugees' perceptions of mental health interventions in Palabek. To illustrate this, the thesis has adopted the study of psychopharmaceuticals – their circulation, prescription, and efficacy – as an analytical lens to examine trends in humanitarian approaches to refugee mental health (Chapter 6), as well as refugees' understandings of the latter (Chapter 7). The thesis has shown that the prescription of psychiatric medication in resource-poor settings cannot be read in isolation from the moral and political context from which it stems, and in which it is introduced; rather, in this practice, existing and harmful tendencies in refugee and global mental health are magnified. The expansion of psychopharmaceutical prescription represents an indicator of individualising and medicalising tendencies in refugee and global mental health, and the wide availability of psychiatric medication leads health workers to prescribe them more (Van der Geest et al. 1996; Beeker 2021), contributing to the depoliticization of complex social, economic, and structural problems. Findings emerging from the study of psychopharmaceuticals in Palabek also apply to other psychosocial interventions, such as CBT-T, by virtue of the shared institutional landscape of the settlement. As noted by Van der Geest and Whyte (1989), in therapeutic relationships medications become an extension of the doctor; non-pharmacological mental health programmes retain a similar metonymic quality, and thus are often perceived an extension of the humanitarian apparatus.

Relatedly, this thesis has shown that efficacy of psychopharmaceuticals, as perceived by users, is a product of the interaction between the drug and the socio-economic and political context in which it is prescribed and ingested (see e.g., Read 2012; Kirmayer and Raikhel 2009). Here, the findings are put in conversation with a large body of medical anthropology literature which has investigated the social lives of pharmaceuticals (e.g., Whyte et al. 2002; Ecks 2014; Han 2012; Oldani et al. 2014), and which has argued that efficacy is locally constructed (Etkin 1992; Van der Geest and Whyte 1989; Jenkins and Kozelka 2017), and that perceptions of therapeutic worth of medications are deeply shaped by social and political dynamics (Tran et al. 2020; Biehl 2005; Chua 2018). By centring refugees' first-hand experiences of psychopharmaceutical treatment, this thesis has shown that approaches that disregard the reality of violent structural circumstances often lead to real harm, such as cycles of non-compliance and illness chronicity (Chapter 7).

Linked to this point, this thesis has shown that people adopt moral strategies to establish a sense of agency, integrity, and control over their lives in displacement, including towards

mental health interventions that are perceived as irrelevant or harmful. In this sense, I propose that non-compliance with medication in Palabek constitute ‘moral experiments’ that refugees employ to reassert a sense of ‘moral personhood’ when faced with adversity (Mattingly 2014; Myers and Yarris 2019). Here, I have sought to place my findings within the recent and ongoing conversation between psychological and medical anthropology, and the anthropology of ethics and morality (e.g., Mattingly 2013, 2014; Myers 2016; Kleinman 2006; Carpenter-Song 2019). This allows us to understand forms of low- and dis-engagement with mental health services noted in refugee settings worldwide (Chapter 1) (see e.g., Fine et al. 2022) as a bottom-up response to the widespread medicalisation of social, economic, and political dimensions in forms of suffering experienced by refugees.

Thirdly, this thesis has traced recent development in the humanitarian and development arena with reference to mental health. It has charted the shifting landscapes of different paradigms of refugee management (Chapters 1 and 4), expanding pharmaceutical economies (Chapter 6 and 7), and changing therapeutic landscapes (Chapters 5 and 9), in reference to both global and Ugandan contexts. I have noted that recent developments in Palabek settlement need to be understood against the backdrop of Uganda’s histories of forced mobility, as well as of implementing mental health interventions, and have illustrated how the rising influence of global mental health leads to increased medicalisation of distress. I have also shown how interrelations of ‘psy’ actors and expertise with local historical contexts may have unforeseen implications, describing how psychosocial actors insert themselves in pre-existing local therapeutic markets and moral economies (Chapter 9), risking furthering long-standing processes of social exclusion through their attempts to assert their own legitimacy. The introduction of these practices unfolds within existing constellations of actors historically involved with the management of affliction, with consequences for people’s local moral worlds and the ways in which suffering is dealt with.

Fourthly, this thesis has argued for the crucial importance of experience-near research in the study of suffering in displacement (Chapter 7 and 8), arguing that centring people’s phenomenological experiences can generate locally relevant ways of understanding affliction, providing a needed alternative to the biomedical psychiatry model (Rose and Rose 2023). In particular I have shown that forms of affliction in Palabek settlement can be helpfully understood in moral and temporal terms (see also Summerfield 2003). In Acholi societies (and elsewhere in Africa), ‘moral personhood’ is achieved to a certain extent through publicly

appraisable displays of participation and social and relational adequacy, often encapsulated by the ability to be 'hardworking' ('latic ma tek'). In the absence of land, economic resources, sufficient humanitarian assistance, or employment opportunities, life in Palabek exacerbates pressures around social performances of moral and ethical personhood, complicating such individual and social statements of social and moral value (Chapter 7 and 8).

This deeply affects the wellbeing of individuals and communities. By focusing on refugee men, a population too often overlooked by humanitarian policy and practice (Turner 2019, 2021; Hyndman and Giles 2011), I have shown how displacement is experienced as a form of 'temporal suspension', akin to what Jackson (2005:xxiii) has described as "a present without one's presence". I have also noted the intersections between psychological affliction and gendered dimensions of "fundamental human processes" (Jenkins 2015) of subjectivity and personhood (Chapter 8). I position my findings in conversation with the recent 'temporal turn' in refugee studies (see e.g., Haas 2017; Ramsay 2020; El-Sharaawi 2021; Jefferson et al. 2019), which identifies time as a fundamental axis of experience in displacement.

Finally, this thesis has also contributed to critiques of the 'trauma' paradigm in refugee and global mental health, by showing the depoliticising effects of temporal assumptions inherent in the diagnostic process (Chapter 8). I have also argued that that therapeutic encounters are shaped by the wider political landscape in which they are embedded (Chapter 5 and 7). In Palabek settlement, the employment of medical technologies which hinder social functioning, and of therapeutic frameworks which disengage from socio-economic and structural adversity becomes a manifestation of systemic abandonment. The prescription of medication whose chemical properties make treatment unsustainable in a food insecure context, makes visible the profound dissonance between the 'success story' narrative around the Ugandan refugee response, and its on-the-ground realities.

2. A way forward: towards a temporal turn in refugee mental health

In 1986, Barbara Harrell-Bond noted the extent to which refugees' suffering in the Uganda-South Sudan borderzone was caused by inadequate assistance – particularly by the mismanagement and insufficiency of food aid. Reading her book, it is striking just how many

of her descriptions of issues with humanitarian aid and assistance delivery have remained the same today. Like the refugees who were the object of her study in 1986, many refugees in Uganda today live in abject poverty, have little hope for future change, and bear the weight of international agendas that have largely failed them.

At the time of her writing, Harrell-Bond (1986) passionately advocated for the need to integrate mental health interventions in the humanitarian response. The focus on mental health in emergency settings could be described as the only element that has meaningfully changed since then; mental health interventions are today a staple of emergency responses, and increasingly populate the humanitarian landscape in Ugandan refugee settlements. Yet, this shift has turned out to be the opposite of what Harrell-Bond envisioned (at a time, it needs to be said, in which there was little talk of mental health in displacement, and PTSD had just emerged as a clinical category in the US). Rather, as this thesis has shown, mental health knowledge, discourses, and practices, have been assimilated by wider development and humanitarian agendas, and used to mask institutional failure and to avoid confronting structural issues. They serve a paradoxical purpose, attending to the wellbeing of the humanitarian apparatus, rather than that of refugees, whose affliction they often exacerbate.

When I began the fieldwork on which this thesis is based, my main research question revolved around refugees' understandings of psychosocial interventions available to them in Palabek settlement, how they engaged with the kind of knowledge these programmes were predicated on, and how they understood the kind of support they provided in relation to their local moral worlds. The assumption underlying this question was that people's experiences of mental health interventions may be relevant enough to elicit commonplace discussions around their practices. It is essential, in these final reflections, to acknowledge that generally, these interventions occupied a very peripheral position in people's lives. Portraying mental health interventions as one of the biggest preoccupations of refugees in Palabek would be inaccurate; while experiences of profound suffering in displacement were common and emerged spontaneously or with minimal prompting in conversations and interviews, the same cannot be said for community or individual psychosocial programmes, which people tended to discuss only when explicitly asked about them.

There were some exceptions, which tended to overlap with instances in which mental disorders were particularly debilitating – both in the depth of the suffering felt, and in the

frequency of episodes. Justin's case (Chapter 7) was one of these; in his tireless efforts to negotiate a space for his own moral agency – with his doctors, with his family, and with the pills themselves – the recurring episodes of his illness became one of his main preoccupations, and over the course of my research I witnessed his tormented relationship with his treatment consume a large part of his time and energies. Simon's (Chapter 8) continuous search for answers about his condition also meant that a large portion of his life to revolved around psychiatric care in the settlement; after abandoning treatment in frustration, every few months he would return to the Health Centre, hopeful that this time, his request for a medical examination that could determine whether an anatomic explanation for his erectile dysfunction may exist. But the doctors knew his case well by then; each time, he was again referred to the mental health clinic and came home with a plastic bag filled with pills, often assured by doctors that the prescription had changed (it had not), and that he would soon see the effects; when I last saw him, this was yet to happen.[78]

For both Justin and Simon, the relationship with (pharmacological) therapy and its providers was, at least at some point, prominent in their lives. But for most other settlement residents, the role of mental health interventions was at best marginal in the wider picture of challenges that they faced in Palabek. People had more pressing concerns, and their minds were largely occupied by other complex and often conflictual relationships; that with WFP and the ever-decreasing rations of maize and beans; that with the doctors at the Health Centres and the frequent lack of medication; that with a border whose porosity granted a degree of freedom, but brought with it the fear that violence may find its way to Palabek; the relationships with unknown 'jogi' that may unintentionally be disturbed by the cutting of trees and grass; those with often strange neighbours and with host communities, whose generosity and hostility

[78] Only many months into my fieldwork did I realise that, contrary to what I had been told initially on more than one occasion, medication for erectile dysfunction is available in Uganda. It is notable that no one, within or outside the Health Centre, had mentioned to Simon that the medication existed. This may be related to a combination of widespread conservative views in medical practice in Uganda, which lead practitioners to refuse to prescribe it, as well as to doctors' perceptions of treatment for erectile dysfunction as not essential. Upon realising that medication was a possibility, I immediately relayed the information to Simon, and helped fund his and his wife Rose's trip to a clinic in Gulu, where I knew a doctor willing to prescribe the treatment. I left Uganda shortly after Simon began taking it; the problem was far from resolved, but he felt hopeful about it for the first time in a long time. I do not mean to suggest that my intervention was in any way resolutory; nor that there was a 'quick fix' to his affliction (which, as I have shown, can be understood as the embodied manifestation of complex and deep-rooted existential, moral, and temporal suffering). Furthermore, my involvement raises the issue of the sustainability of treatment, which was contingent on my financial support. But it is relevant to my point in this thesis to at least mention that it was a solution which centred his priorities, as defined by himself, and which gave him hope – however briefly.

were as remarkable as they were unpredictable; that with their own families and networks both in the settlement and back in South Sudan, and with the social and moral expectations that filled these relational lifeworlds; and finally, the relationship with the struggle of building a life without access to land, which required accepting the precariousness of available survival strategies.

The 'extraordinary conditions' of life in Palabek refugee settlement are productive of complex and multi-layered experiences of insecurity, anxiety, fear, and temporal suspension, which as I have shown were frequently expressed among South Sudanese Acholi refugees through idioms of 'overthinking' ('tam ma dwong') and 'stuckness of the head' ('wic omoko'). Indeed, this thesis has argued that the widespread and growing rates of psychological suffering in the settlement are largely attributable to conditions of chronic poverty and food insecurity produced by the shortcomings and corruption of the Ugandan refugee response, which need to be openly acknowledged as generating extensive individual and social suffering.

Despite widespread forms of emotional and existential affliction, psychosocial and psychopharmacological interventions in Palabek seemed generally to be of very little consequence to most refugees. As an ethics of 'radical empiricism' (Chapter 3) requires the research to be attuned to people's priorities, it became necessary to expand the original research question, to look at the reasons underlying the lack of relevance and perceived efficacy of these programmes; and to question what role the latter played in Palabek's humanitarian landscape, where their supposed beneficiaries largely experienced them as irrelevant, failing, or even harmful.

The ethnographic findings presented in this thesis suggest that the problem at the root of low and dis-engagement with mental health services and interventions in extremely low-resource settings such as Palabek lies deeper than simply the accessibility of services. Similarly to what Luhrmann noted in her study of homeless women in Chicago, among refugees in Palabek refusal of (and negative attitudes towards) mental health services and interventions do not simply stem from lack of insight or of 'mental health literacy', but are rather to be understood as a "meaningful social signal" (2016:19), which refugees employ as a communication response to the medicalization of distress that they experience in these clinical settings.

As I have shown, in Palabek settlement refugees tend to understand forms of psychological affliction not as psychological affliction, but as normal reaction to the adversity that characterises their living circumstances (see also Summerfield 2008; Ventevogel et al. 2013; Esponda et al. 2022; Clark 2014). As perceptions of efficacy of mental health interventions cannot be divorced from improvement of material conditions, the role of contextual socio-economic and structural characteristics in shaping experiences of distress, emerges as paramount in shaping the perceived symbolic meaning and many refugees' experience of mental health programmes in Palabek settlement. This implies that the interventions offered, no matter how many efforts may be made towards their 'cultural relevance', simply do not speak to people's needs of observing actual, meaningful change in their daily lives, in so far as they remain limited to the psychological realm (Roberts et al. 2022; Pathare et al. 2018).

In the era of global mental health, recent qualitative studies have generated similar findings across diverse low-income settings (see e.g., Jansen and colleagues' (2015) study in Rwanda, Burgess' work on low-income Black and Caribbean communities in the UK (Burgess et al. 2022), and Esponda and colleagues' (2022) study in rural Mexico). A paper to which I contributed and draws on insights from my PhD research (Roberts et al. 2022) (Appendix 2) also calls for a reconceptualization of the concept of 'treatment gap'; central in global mental health policy and practice, the 'treatment gap' relies on the psychocentric assumption that individuals and communities living under 'extraordinary conditions' of structural adversity and psychological affliction in the Global South envision care needs in psychological terms. This thesis has shown that a gap does exist but can be better conceptualised as the difference between what global mental health interventions currently address (psychological manifestations of suffering) and what global mental health *should* leverage their influence to address (socio-economic and structural determinants of affliction).

I share Whitley's (2014) view that anthropology of (global) mental health should offer "no opposition without proposition" (ibid:501). With growing recognition of the role of structural injustices in shaping (mental) health outcomes (Patel and Farmer 2020), it is not implausible to suggest that there is momentum for a paradigm shift in global mental health – one in which a narrow focus on access to services is replaced by approaches that foreground person-centred care and community knowledge (Burgess et al. 2023), and are explicitly oriented towards improving social justice (see e.g., Pathare et al. 2021). Building on these theoretical

contributions, as well as on those put forward in this thesis, one such approach could be conceptualised as a ‘temporal turn’ in global mental health policy and practice, where several innovative approaches converge.

By proposing a ‘temporal turn’ in global mental health, I envision a framework for understanding conditions of afflictions under circumstances of socio-structural adversity (Kumar et al. 2023), centred around priorities identified by users, foregrounding social functioning, and temporal and moral agency (Read 2012; Jenkins and Kozelka 2017). In the case of refugees in Palabek, my research suggests it may be meaningful to centre moral and relational dimensions of subjectivity. This would entail abandoning psychocentric assumptions which dictate that both causes of and solutions to psychological suffering must be psychological in nature. Harrell-Bond’s argument that, were a minimal standard of living to be granted in refugee settlements, “much illness would not occur” (1986:203) is still relevant almost four decades later, and as this thesis demonstrates certainly applies to mental health as well. The minimal acknowledgement needs to be that in the absence of basic needs, psychocentric interventions are not simply inadequate to address conditions of suffering, but risk being perceived by users as disengaged and hostile and may cause real harm.

This proposition rests on the simple claim that therapeutic value needs to be sought in interventions whose need is clearly identified by users; in Palabek settlement an explicit engagement with socio-economic conditions is essential in mediating mental health outcomes. As Harrell-Bond has put it, “any aid programme must begin by looking at the world from the bottom up, by learning how to see how the recipients of aid perceive their opportunities, responsibilities, and constraints. Any programme which consistently ignores these factors is doomed at the outset” (1986:249). Thus, a ‘temporal turn’ is not just an epistemological, but an ethical project for humanitarian and global mental health, and one crucially oriented towards notions of recovery (see e.g., Myers 2016). What is needed, I think, is a recognition of the therapeutic potential of social and – crucially – livelihood interventions (Burgess et al. 2020; Haushofer et al. 2021), particularly in displacement settings, allowing for a re-politicisation and re-appropriation of temporally dispossessing circumstances, and for the performance of culturally determined forms of ‘moral personhood’, unfolding across relational and gendered dimensions (Myers and Yarris 2019; Yarris and Ponting 2019).

As Jackson notes, "human wellbeing […] involves endless experimentation in how the given world can be lived decisively, on one's own terms" (2005:xiv; see also Mattingly 2014; Kleinman 2006). To have any hope of avoiding repeated instances of epistemic injustice, interventions' design and implementation should be rooted in the identification of priorities from below (Kumar 2023; Roberts et al. 2022; Burgess et al. 2023). A decolonial stance is key to an ethical project in global mental health (although I am deeply aware of the contradictions embedded in advocating for disciplinary decolonization from a position of multiple intersecting privileges). Yet, it seems likely that until international academic and policy hubs in the Global North effectively step back from setting the global mental health agenda, psychological affliction and mental disorders across the Global South will continue to be approached in the way in which development programmes often approach complex issues, by reducing them to technical issues (Li 2007; Kaiser 2000). Mental health interventions will keep being based in pathologising, biomedical models of distress. They will continue to reproduce the colonial epistemic and relational dynamics in which they are embedded, and to reflect development goals shaped by individualising neoliberal agendas; and, crucially, they will continue to depoliticise forms of structural violence and social suffering, while marginalised voices and alternative approaches will remain side-lined (Kumar et al. 2023; Lovell et al. 2019).

3. Further research

This thesis has opened pathways for generative and co-produced research in refugee and global mental health. My sense is that work would be useful on feasible avenues for future-making that are sustainable in the socio-political context in which they are introduced and are centred around priorities and dimensions identified by affected individuals and groups. More research is needed into some of the processes that this thesis has sought to trace and analyse, including the rising influence of global mental health on humanitarian and refugee policies and the expansion of psychopharmaceutical prescription and use in displacement settings. In Uganda, future work should continue to observe new and evolving interrelations between refugees and mental health interventions in the context of repeated and devastating cuts to emergency assistance, and particularly food rations (e.g., Stein et al. 2022; WFP 2023). In addition, further research is needed into first-hand experiences of mental illness, temporality,

and personhood in displacement; new directions for work might span across gendered, age, and socio-economic dimensions.

Crucially, future research in the anthropology of global mental health, particularly as it relates to displaced individuals and communities, will need to continuously critically reflect on how to translate theoretical propositions of social justice into practice. The task, I think, will be for researchers to communicate their findings to wider audiences, maintaining the complexity and nuance that ethnography allows for, while at the same time convincingly advocating for structural change. This is made particularly challenging by a political landscape increasingly (and often violently) hostile to forced mobility, and at best reluctant to invest in sustainable solutions for refugees' wellbeing.

Ultimately, however, As noted by Hopwood (2022), a wider recognition of the role of Global North research institutions in dictating the global research agenda is needed. Researchers from Global North institutions must recognise their role in furthering interests that may not align or even overlap with those of the communities they study. It is likely, and in my view desirable, that future research in refugee studies may gradually merge into forms of political engagement, led by forced migrant individuals and communities, where the role of researchers originating from the Global North may resemble more a form of engaged intellectual support of priorities defined from below. Ultimately, the need is for Global North institutions to step back, and for global (mental) health research and social justice agendas to be determined by the people whose lives are directly affected by them.

References

Abramowitz, S. A. (2010). Trauma and Humanitarian Translation in Liberia: The Tale of Open Mole. *Culture, Medicine, and Psychiatry*, *34*(2), 353–379. https://doi.org/10.1007/s11013-010-9172-0

Abramowitz, S. A. (2014). Searching for Normal in the Wake of the Liberian War. In *Searching for Normal in the Wake of the Liberian War*. University of Pennsylvania Press, (July. http://www.jstor.org/stable/j.ctt6wr9k6

Abramowitz, S., & Kleinman, A. (2008). *Humanitarian intervention and cultural translation: A review of the*. *6*(3), 9.

Abramowitz, S., & Panter-Brick, C. (Eds.). (2015). *Medical Humanitarianism: Ethnographies of Practice*. University of Pennsylvania Press.

Abramson, A., & Holbraad, M. (2012). Contemporary Cosmologies, Critical Reimaginings. *Religion and Society*, *3*(1), 35–50. https://doi.org/10.3167/arrs.2012.030103

Acarturk, C., Uygun, E., Ilkkursun, Z., Yurtbakan, T., Kurt, G., Adam-Troian, J., Senay, I., Bryant, R., Cuijpers, P., Kiselev, N., McDaid, D., Morina, N., Nisanci, Z., Park, A. L., Sijbrandij, M., Ventevogel, P., & Fuhr, D. C. (2022). Group problem management plus (PM+) to decrease psychological distress among Syrian refugees in Turkey: A pilot randomised controlled trial. *BMC Psychiatry*, *22*(1), 8. https://doi.org/10.1186/s12888-021-03645-w

Adaku, A., Okello, J., Lowry, B., Kane, J. C., Alderman, S., Musisi, S., & Tol, W. A. (2016). Mental health and psychosocial support for South Sudanese refugees in northern Uganda: A needs and resource assessment. *Conflict and Health*, *10*(1), 18. https://doi.org/10.1186/s13031-016-0085-6

Adams, C. E., Awad, G. A., Rathbone, J., Thornley, B., & Soares-Weiser, K. (2014). Chlorpromazine versus placebo for schizophrenia. *Cochrane Database of Systematic Reviews*, *1*. https://doi.org/10.1002/14651858.CD000284.pub3

Affleck, W. (2018). "If One Does Not Fulfil His Duties, He Must Not Be a Man": Masculinity, Mental Health and Resilience Amongst Sri Lankan Tamil Refugee Men in Canada. *Cult Med Psychiatry*, 22.

Ahmed, S. (2014). *The cultural politics of emotion* (Second edition). Edinburgh University Press.

Allen, T. (1989a). Full Circle?: An Overview of Sudan's 'Southern Problem' Since Independence. *Northeast African Studies*, *11*(2), 41–66.

Allen, T. (1989b). Violence and Moral Knowledge: Observing Social Trauma in Sudan and Uganda. *The Cambridge Journal of Anthropology*, *13*(2), 23.

Allen, T. (1993). *Social Upheaval and the Struggle for Community: a Study of the Ugandan Madi* [PhD Thesis]. University of Manchester.

Allen, T. (Ed.). (1996). *In Search of Cool Ground: War, Flight & Homecoming in Northeast Africa*. Africa World Press.

Allen, T. (2010). Bitter Roots: The 'invention' of Acholi traditional justice. In T. Allen & K. Vlassenroot (Eds.), *The Lord's Resistance Army: Myth and Reality*. Zed Books Ltd. https://doi.org/10.5040/9781350223240

Allen, T. (2015). Life Beyond the Bubbles: Cognitive Dissonance and Humanitarian Impunity in Northern Uganda. In S. Abramowitz & C. Panter-Brick (Eds.), *Medical Humanitarianism: Ethnographies of Practice* (pp. 96–118). University of Pennsylvania Press.

Allen, T., Atingo, J., & Parker, M. (2022). Rejection and Resilience: Returning from the Lord's Resistance Army in Northern Uganda. *Civil Wars*, *24*(2–3), 357–384. https://doi.org/10.1080/13698249.2022.2015195

Allen, T., & Turton, D. (1996). Introduction. In T. Allen (Ed.), *In Search of Cool Ground: War, Flight & Homecoming in Northeast Africa* (pp. 1–22). Africa World Press.

Allen, T., & Vlassenroot, K. (Eds.). (2010). *The Lord's Resistance Army: Myth and Reality*. Zed Books Ltd. https://doi.org/10.5040/9781350223240

Anakwenze, O. (2022). The cultural sensitivity continuum of mental health interventions in Sub-Saharan Africa: A systematic review. *Social Science & Medicine*, *306*, 115124. https://doi.org/10.1016/j.socscimed.2022.115124

Anderson, B. (2009). Affective atmospheres. *Emotion, Space and Society*, *2*(2), 77–81. https://doi.org/10.1016/j.emospa.2009.08.005

Andreasen, N. C. (2004). Acute and Delayed Posttraumatic Stress Disorders: A History and Some Issues. *American Journal of Psychiatry*, *161*(8), 1321–1323. https://doi.org/10.1176/appi.ajp.161.8.1321

Angell, M. (2011). The Epidemic of Mental Illness: Why? | Marcia Angell. *The New York Review of Books*, *58*(11). https://www.nybooks.com/articles/2011/06/23/epidemic-mental-illness-why/

Aradau, C., & Tazzioli, M. (2020). Biopolitics Multiple: Migration, Extraction, Subtraction. *Millennium*, *48*(2), 198–220. https://doi.org/10.1177/0305829819889139

Argenti-Pillen, A. (2013). *Masking Terror: How Women Contain Violence in Southern Sri Lanka*. University of Pennsylvania Press.

Atube, F., Malinga, G. M., Nyeko, M., Okello, D. M., Mugonola, B., Omony, G. W., & Okello-Uma, I. (2022). Farmers' perceptions of climate change, long-term variability and trends in rainfall in Apac district, northern Uganda. *CABI Agriculture and Bioscience*, *3*(1), 46. https://doi.org/10.1186/s43170-022-00116-4

Bäärnhielm, S., Laban, K., Schouler-Ocak, M., Rousseau, C., & Kirmayer, L. J. (2017). Mental health for refugees, asylum seekers and displaced persons: A call for a humanitarian agenda. *Transcultural Psychiatry*, *54*(5–6), 565–574. https://doi.org/10.1177/1363461517747095

Backe, E. L., Bosire, E. N., Kim, A. W., & Mendenhall, E. (2021). "Thinking Too Much": A Systematic Review of the Idiom of Distress in Sub-Saharan Africa. *Culture, Medicine, and Psychiatry*, *45*(4), 655–682. https://doi.org/10.1007/s11013-020-09697-z

Baines, E. (2005). *Roco Wat I Acoli Restoring Relationships in Acholi-land: Traditional Approaches to Justice and Reintegration*. Liu Institute for Global Issues.

Baines, E. (2010). Spirits and social reconstruction after mass violence: Rethinking transitional justice. *African Affairs*, *109*(436), 409–430. https://doi.org/10.1093/afraf/adq023

Baines, E., & Paddon, E. (2012). 'This is how we survived': Civilian agency and humanitarian protection. *Security Dialogue*, *43*(3), 231–247. https://doi.org/10.1177/0967010612444150

Baldwin, M. R., Yori, P. P., Ford, C., Moore, D. A. J., Gilman, R. H., Vidal, C., Ticona, E., & Evans, C. A. (2004). Tuberculosis and nutrition: Disease perceptions and health seeking behavior of household contacts in the Peruvian Amazon. *The International Journal of Tuberculosis and Lung Disease*, *8*(12), 1484–1491.

Ban, T. A. (2007). Fifty years chlorpromazine: A historical perspective. *Neuropsychiatric Disease and Treatment*, *3*(4), 495–500.

Bangpan, M., Felix, L., & Dickson, K. (2019). Mental health and psychosocial support programmes for adults in humanitarian emergencies: A systematic review and meta-analysis in low and middle-income countries. *BMJ Global Health*, *4*(5), e001484. https://doi.org/10.1136/bmjgh-2019-001484

Barbui, C. (2022). The WHO World Mental Health Report 2022: A new standard of care is emerging. *Molecular Psychiatry*, 1–2. https://doi.org/10.1038/s41380-022-01788-0

Barnett, M. N. (2013). Humanitarian Governance. *Annual Review of Political Science*, *16*(1), 379–398. https://doi.org/10.1146/annurev-polisci-012512-083711

Baron, N. (2002). Community Based Psychosocial and Mental Health Services for Southern Sudanese Refugees in Long Term Exile in Uganda. In J. De Jong (Ed.), *Trauma, War, and Violence: Public Mental Health in Socio-Cultural Context* (pp. 157–203). Springer US. https://doi.org/10.1007/0-306-47675-4_3

Batniji, R., Van Ommeren, M., & Saraceno, B. (2006). Mental and social health in disasters: Relating qualitative social science research and the Sphere standard. *Social Science & Medicine*, *62*(8), 1853–1864. https://doi.org/10.1016/j.socscimed.2005.08.050

Bauer, A., Garman, E., McDaid, D., Avendano, M., Hessel, P., Díaz, Y., Araya, R., Lund, C., Malvasi, P., Matijasevich, A., Park, A.-L., Paula, C. S., Ziebold, C., Zimmerman, A., & Evans-Lacko, S. (2021). Integrating youth mental health into cash transfer programmes in response to the COVID-19 crisis in low-income and middle-income countries. *The Lancet Psychiatry*, *8*(4), 340–346. https://doi.org/10.1016/S2215-0366(20)30382-5

Bear, L. (2016). Time as Technique. *Annual Review of Anthropology*, *45*(1), 487–502. https://doi.org/10.1146/annurev-anthro-102313-030159

Beeker, T., Mills, C., Bhugra, D., te Meerman, S., Thoma, S., Heinze, M., & von Peter, S. (2021). Psychiatrization of Society: A Conceptual Framework and Call for Transdisciplinary Research. *Frontiers in Psychiatry*, *12*, 645556. https://doi.org/10.3389/fpsyt.2021.645556

Behrend, H. (2011). Resurrecting Cannibals: The Catholic Church, Witch-hunts, and the Production of Pagans in Western Uganda. Boydell & Brewer Ltd.

Behrouzan, O. (2015). Medicalization as a way of life. *Medicine Anthropology Theory*, *2*(3), Article 3. https://doi.org/10.17157/mat.2.3.199

Belle, D. (1990). Poverty and women's mental health. *American Psychologist*, *45*(3), 385. https://doi.org/10.1037/0003-066X.45.3.385

Bemme, D., & D'souza, N. A. (2014). Global mental health and its discontents: An inquiry into the making of global and local scale. *Transcultural Psychiatry*, *51*(6), 850–874. https://doi.org/10.1177/1363461514539830

Bemme, D., & Kirmayer, L. J. (2020). Global Mental Health: Interdisciplinary challenges for a field in motion. *Transcultural Psychiatry*, *57*(1), 3–18. https://doi.org/10.1177/1363461519898035

Beneduce, R. (2008). Undocumented bodies, burned identities: Refugees, sans papiers, harraga — when things fall apart. *Social Science Information*, *47*(4), 505–527. https://doi.org/10.1177/0539018408096444

Berke, T., & Larsen, L. (2022). Using Land to Promote Refugee Self-Reliance in Uganda. *Land*, *11*(3), 410. https://doi.org/10.3390/land11030410

Bernstein, J. G. (1988). Psychotropic drug induced weight gain: Mechanisms and management. *Clinical Neuropharmacology*, *11 Suppl 1*, S194-206.

Betts, A., Bloom, L., Kaplan, J. D., & Omata, N. (2017). *Refugee economies: Forced displacement and development* (First edition). Oxford University Press.

Betts, D. A., Bloom, L., Kaplan, D. J., & Omata, D. N. (2014). *Refugee Economies: Rethinking Popular Assumptions* (1st ed.). Refugees Studies Centre.

Biehl, J. (2004). Life of the mind: The interface of psychopharmaceuticals, domestic economies, and social abandonment. *American Ethnologist*, *31*(4), 475–496. https://doi.org/10.1525/ae.2004.31.4.475

Biehl, J. (2010). CATKINE…Asylum, laboratory, pharmacy, pharmacist, I and the cure. In J. H. Jenkins (Ed.), *Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacology* (pp. 67–96). School for Advanced Research Press. http://joaobiehl.net/wp-content/uploads/2009/07/pharmaceutical-self.pdf

Biehl, J. G. (2005). *Vita: Life In A Zone Of Social Abandonment*. Univ of California Pr.

Biehl, K. S. (2015). Governing through Uncertainty: Experiences of Being a Refugee in Turkey as a Country for Temporary Asylum. *Social Analysis*, *59*(1), 57–75. https://doi.org/10.3167/sa.2015.590104

Billo, E., & Hiemstra, N. (2013). Mediating messiness: Expanding ideas of flexibility, reflexivity, and embodiment in fieldwork. *Gender, Place & Culture*, *20*(3), 313–328. https://doi.org/10.1080/0966369X.2012.674929

Bimeny, P. (2022). *The Constructions of the State, Violence and Political Settlement in South Sudan* [School of Oriental and African Studies, University of London]. https://doi.org/10.25501/SOAS.00038360

Bjertrup, P. J., Bouhenia, M., Mayaud, P., Perrin, C., Ben Farhat, J., & Blanchet, K. (2018). A life in waiting: Refugees' mental health and narratives of social suffering after European Union border closures in March 2016. *Social Science & Medicine*, *215*, 53–60. https://doi.org/10.1016/j.socscimed.2018.08.040

Bohnet, H., & Schmitz-Pranghe, C. (2019). *Uganda: A role model for refugee integration?* (Vol. 2/2019). Bonn International Center for Conversion (BICC).

Bolton, P. (2019). 1 - Global mental health and psychotherapy: Importance of task-shifting and a systematic approach to adaptation. In D. J. Stein, J. K. Bass, & S. G. Hofmann (Eds.), *Global Mental Health and Psychotherapy* (pp. 11–24). Academic Press. https://doi.org/10.1016/B978-0-12-814932-4.00001-X

Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P., Speelman, L., Ndogoni, L., & Weissman, M. (2003). Group interpersonal psychotherapy for depression in rural Uganda: A randomized controlled trial. *JAMA*, *289*(23), 3117–3124. https://doi.org/10.1001/jama.289.23.3117

Bonhomme, J. (2012). The dangers of anonymity: Witchcraft, rumor, and modernity in Africa. *HAU: Journal of Ethnographic Theory*, *2*(2), 205–233. https://doi.org/10.14318/hau2.2.012

Bracken, P. (2002). *Trauma: Culture, Meaning and Philosophy* (1st edition). John Wiley & Sons.

Bracken, P., Giller, J., & Summerfield, D. (2016). Primum non nocere. The case for a critical approach to global mental health. *Epidemiology and Psychiatric Sciences*, *25*(6), 506–510. https://doi.org/10.1017/S2045796016000494

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995a). Psychological responses to war and atrocity: The limitations of current concepts. *Social Science & Medicine*, *40*(8), 1073–1082. https://doi.org/10.1016/0277-9536(94)00181-R

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995b). Psychological responses to war and atrocity: The limitations of current concepts. *Social Science & Medicine (1982)*, *40*(8), 1073–1082. https://doi.org/10.1016/0277-9536(94)00181-r

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., Bhunnoo, S., Browne, I., Chhina, N., Double, D., Downer, S., Evans, C., Fernando, S., Garland, M. R., Hopkins, W., Huws, R., Johnson, B., Martindale, B., Middleton, H., … Yeomans, D. (2012). Psychiatry beyond the current paradigm. *British Journal of Psychiatry*, *201*(6), 430–434. https://doi.org/10.1192/bjp.bp.112.109447

Branch, A., Agyei, F. K., Anai, J. G., Apecu, S. L., Bartlett, A., Brownell, E., Caravani, M., Cavanagh, C. J., Fennell, S., Langole, S., Mabele, M. B., Mwampamba, T. H., Njenga, M., Owor, A., Phillips, J., & Tiitmamer, N. (2022). From crisis to context: Reviewing the future of sustainable charcoal in Africa. *Energy Research & Social Science*, *87*, 102457. https://doi.org/10.1016/j.erss.2021.102457

Branch, A., & Yen, A. L. S. (2018). Neoliberal discipline and violence in northern Uganda. In J. Wiegratz, G. Martiniello, E. Greco, J. Wiegratz, G. Martiniello, & E. Greco (Eds.), *Uganda: The dynamics of neoliberal transformation*. Zed Books.

Brankamp, H. (2021). ‘Madmen, womanizers, and thieves’: Moral disorder and the cultural text of refugee encampment in Kenya. *Africa*, *91*(1), 153–176. https://doi.org/10.1017/S000197202000100X

Braslow, J. T., & Marder, S. R. (2019). History of Psychopharmacology. *Annual Review of Clinical Psychology*, *15*(1), 25–50. https://doi.org/10.1146/annurev-clinpsy-050718-095514

Brauer, R., Alfageh, B., Blais, J. E., Chan, E. W., Chui, C. S. L., Hayes, J. F., Man, K. K. C., Lau, W. C. Y., Yan, V. K. C., Beykloo, M. Y., Wang, Z., Wei, L., & Wong, I. C. K. (2021). Psychotropic medicine consumption in 65 countries and regions, 2008–19: A longitudinal

study. *The Lancet Psychiatry*, *8*(12), 1071–1082. https://doi.org/10.1016/S2215-0366(21)00292-3

Breslau, J. (2004). Introduction: Cultures of Trauma: Anthropological Views of Posttraumatic Stress Disorder in International Health. *Culture, Medicine and Psychiatry*, *28*(2), 113–126. https://doi.org/10.1023/B:MEDI.0000034421.07612.c8

Brown, R., Witt, A., Fegert, J., Keller, F., Rassenhofer, M., & Plener, P. (2017). Psychosocial interventions for children and adolescents after man-made and natural disasters: A meta-analysis and systematic review. *Psychological Medicine*, *47*, 1–13. https://doi.org/10.1017/S0033291717000496

Brun, C. (2015). Active Waiting and Changing Hopes: Toward a Time Perspective on Protracted Displacement. *Social Analysis*, *59*(1), 19–37. https://doi.org/10.3167/sa.2015.590102

Brun, C. (2016). There is no Future in Humanitarianism: Emergency, Temporality and Protracted Displacement. *History and Anthropology*, *27*(4), 393–410. https://doi.org/10.1080/02757206.2016.1207637

Bryant, R. A., Bawaneh, A., Awwad, M., Al-Hayek, H., Giardinelli, L., Whitney, C., Jordans, M. J. D., Cuijpers, P., Sijbrandij, M., Ventevogel, P., Dawson, K., & Akhtar, A. (2022). Twelve-month follow-up of a randomised clinical trial of a brief group psychological intervention for common mental disorders in Syrian refugees in Jordan. *Epidemiology and Psychiatric Sciences*, *31*, e81. https://doi.org/10.1017/S2045796022000658

Buhmann, C. B., Nordentoft, M., Ekstroem, M., Carlsson, J., & Mortensen, E. L. (2018). Long-term treatment effect of trauma-affected refugees with flexible cognitive behavioural therapy and antidepressants. *Psychiatry Research*, *264*, 217–223. https://doi.org/10.1016/j.psychres.2018.03.069

Bukuluki, P., Kisaakye, P., Wandiembe, S. P., & Besigwa, S. (2021). Suicide ideation and psychosocial distress among refugee adolescents in Bidibidi settlement in West Nile, Uganda. *Discover Psychology*, *1*(1), 3. https://doi.org/10.1007/s44202-021-00003-5

Bukuluki, P., Mwenyango, H., Katongole, S. P., Sidhva, D., & Palattiyil, G. (2020). The socio-economic and psychosocial impact of Covid-19 pandemic on urban refugees in Uganda. *Social Sciences & Humanities Open*, *2*(1), 100045. https://doi.org/10.1016/j.ssaho.2020.100045

Burgess, R. A. (2022a). *The struggle for the social: Rejecting a false separation in our engagement with 'social' worlds in mental health spaces* [Preprint]. In Review. https://doi.org/10.21203/rs.3.rs-2069635/v1

Burgess, R. A. (2022b). Working in the wake: Transformative global health in an imperfect world. *BMJ Global Health*, *7*(9), e010520. https://doi.org/10.1136/bmjgh-2022-010520

Burgess, R. A., Jain, S., Petersen, I., & Lund, C. (2020). Social interventions: A new era for global mental health? *The Lancet Psychiatry*, *7*(2), 118–119. https://doi.org/10.1016/S2215-0366(19)30397-9

Burgess, R. A., Kanu, N., Matthews, T., Mukotekwa, O., Smith-Gul, A., Yusuf, I., Lamptey, I., McCauley, N., Wilson, R., Pirisola, M., & Gul, M. (2022). Exploring experiences and impact of the COVID-19 pandemic on young racially minoritised people in the United Kingdom: A qualitative study. *PLOS ONE*, *17*(5), e0266504. https://doi.org/10.1371/journal.pone.0266504

Burgess, R. A., Shittu, F., Iuliano, A., Haruna, I., Valentine, P., Bakare, A. A., Colbourn, T., Graham, H. R., McCollum, E. D., Falade, A. G., King, C., Ahmed, T., Ahmar, S., Cassar, C., Isah, A., Osebi, A., Magama, A., Seriki, I., Olowookere, T. F., … on behalf of the INSPIRING Project Consortium. (2023). Whose knowledge counts? Involving communities in intervention and trial design using community conversations. *Trials*, *24*(1), 385. https://doi.org/10.1186/s13063-023-07320-1

Bwesige, M. M., & Snider, L. (2021). Despair and Suicide-Related Behaviours in Palorinya Refugee Settlement, Moyo, Uganda. *Intervention*, *19*(2), 224. https://doi.org/10.4103/INTV.INTV_12_21

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review*, *75*, 101812. https://doi.org/10.1016/j.cpr.2019.101812

Cabot, H., & Ramsay, G. (2021). Deexceptionalizing Displacement: An Introduction. *Humanity: An International Journal of Human Rights, Humanitarianism, and Development*, *12*(3), 286–299. https://doi.org/10.1353/hum.2021.0028

Çaglar, A., & Glick Schiller, N. (2018). *Migrants and City-Making: Dispossession, Displacement, and Urban Regeneration*. Duke University Press. https://library.oapen.org/handle/20.500.12657/25763

Calhoun, C. (2010). The Idea of Emergency: Humanitarian Action and Global (Dis)order. In D. Fassin & M. Pandolfi (Eds.), *Contemporary states of emergency: The politics of military and humanitarian inventions* (1. paperback ed, pp. 29–58). MIT Press.

Campbell, C., & Burgess, R. (2012). The role of communities in advancing the goals of the Movement for Global Mental Health. *Transcultural Psychiatry*, *49*(3–4), 379–395. https://doi.org/10.1177/1363461512454643

Campion, J., Javed, A., Lund, C., Sartorius, N., Saxena, S., Marmot, M., Allan, J., & Udomratn, P. (2022). Public mental health: Required actions to address implementation failure in the context of COVID-19. *The Lancet Psychiatry*, *9*(2), 169–182. https://doi.org/10.1016/S2215-0366(21)00199-1

Cange, C. W., Brunell, C., Acarturk, C., & Fouad, F. M. (2019). Considering chronic uncertainty among Syrian refugees resettling in Europe. *The Lancet Public Health*, *4*(1), e14. https://doi.org/10.1016/S2468-2667(18)30261-5

Carlson, C., Sweetland, A., & Wainberg, M. (2018). Ethical challenges in global mental health clinical trials. *The Lancet. Psychiatry*, *5*(11), 866–867. https://doi.org/10.1016/S2215-0366(18)30300-6

Center for Public Interest Law (CEPIL). (n.d.). *THE MENTAL HEALTH ACT 2018*. https://cepiluganda.org/cepil-legal-briefs/what-you-need-to-know-about-the-mental-health-act-2018/

Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: A systematic review and meta-analysis. *The Lancet*, *394*(10194), 240–248. https://doi.org/10.1016/S0140-6736(19)30934-1

Checchi, F., Testa, A., Warsame, A., Bs, L. Q., & Burns, R. (2018). *Estimates of crisis-attributable mortality in South Sudan, December 2013-April 2018: A statistical analysis*. https://www.lshtm.ac.uk/south-sudan-full-report

Chee, L. (2020). "Supermaids": Hyper-resilient Subjects in Neoliberal Migration Governance. *International Political Sociology*, *14*(4), 366–381. https://doi.org/10.1093/ips/olaa009

Chen, L. W.-H., Chen, M. Y.-S., Lian, Z.-P., Lin, H.-S., Chien, C.-C., Yin, H.-L., Chu, Y.-H., & Chen, K.-Y. (2018). Amitriptyline and Sexual Function: A Systematic Review Updated for Sexual Health Practice. *American Journal of Men's Health*, *12*(2), 370–379. https://doi.org/10.1177/1557988317734519

Cherepanov, E. (2018). *Ethics for Global Mental Health: From Good Intentions to Humanitarian Accountability*. Routledge. https://doi.org/10.4324/9781351175746

Chibanda, D., Verhey, R., Munetsi, E., Rusakaniko, S., Cowan, F., & Lund, C. (2016). Scaling up interventions for depression in sub-Saharan Africa: Lessons from Zimbabwe. *Cambridge Prisms: Global Mental Health*, *3*, e13. https://doi.org/10.1017/gmh.2016.8

Chiumento, A., Dickson, K., Felix, L., & Bangpan, M. (2017). *The Impact of Mental Health and Psychosocial Support Interventions on People Affected by Humanitarian Emergencies: A*

systematic review. Oxfam; Feinstein International Center; UKAID. https://doi.org/10.21201/2017.8937

Chiumento, A., Rutayisire, T., Sarabwe, E., Hasan, M. T., Kasujja, R., Nabirinde, R., Mugarura, J., Kagabo, D. M., Bangirana, P., Jansen, S., Ventevogel, P., Robinson, J., & White, R. G. (2020). Exploring the mental health and psychosocial problems of Congolese refugees living in refugee settings in Rwanda and Uganda: A rapid qualitative study. *Conflict and Health*, *14*(1), 77. https://doi.org/10.1186/s13031-020-00323-8

Chokhawala, K., & Stevens, L. (2022). Antipsychotic Medications. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK519503/

Chouliaraki, L., & Stolic, T. (2017). Rethinking media responsibility in the refugee 'crisis': A visual typology of European news. *Media, Culture & Society*, *39*(8), 1162–1177. https://doi.org/10.1177/0163443717726163

Chua, J. L. (2018). Fog of War: Psychopharmaceutical "Side Effects" and the United States Military. *Medical Anthropology*, *37*(1), 17–31. https://doi.org/10.1080/01459740.2016.1235571

Clark, J. (2014a). Medicalization of global health 1: Has the global health agenda become too medicalized? *Global Health Action*, *7*(s3), 23998. https://doi.org/10.3402/gha.v7.23998

Clark, J. (2014b). Medicalization of global health 2: The medicalization of global mental health. *Global Health Action*, *7*(1), 24000. https://doi.org/10.3402/gha.v7.24000

Clark, T. (2008). `We're Over-Researched Here!': Exploring Accounts of Research Fatigue within Qualitative Research Engagements. *Sociology*, *42*(5), 953–970. https://doi.org/10.1177/0038038508094573

Cleaver, F. (Ed.). (2002). *Masculinities Matter!: Men, Gender and Development* (1st edition). Zed Books.

Clements, K. T., Shoffner, T., & Zamore, L. (2016). Uganda's approach to refugee self-reliance. *Forced Migration Review*, *52*, 49.

Clifford, J., & Marcus, G. E. (Eds.). (1986). *Writing Culture: The Poetics and Politics of Ethnography, 25th Anniversary Edition* (2nd ed.).

Cohen, B. M. Z. (2021). A postcolonial critique of mental health: Empire and psychiatric expansionism. In *The Routledge International Handbook of Race, Culture and Mental Health*. Routledge.

Cohen, F. (2021). Ecologies of Care for Serious Mental Illness in Uganda: A Scoping Review. *Global Social Welfare*, *8*(4), 301–315. https://doi.org/10.1007/s40609-020-00193-1

Cojocaru, O. (2016). *Time and migration studies: Theoretical and methodological intersections*.

Coker, E. M. (2004). “Traveling Pains”: Embodied Metaphors of Suffering Among Southern Sudanese Refugees in Cairo. *Culture, Medicine and Psychiatry*, *28*(1), 15–39. https://doi.org/10.1023/B:MEDI.0000018096.95218.f4

Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel, T. R., Daar, A. S., Bordin, I. A., Costello, E. J., Durkin, M., Fairburn, C., Glass, R. I., Hall, W., Huang, Y., Hyman, S. E., Jamison, K., Kaaya, S., Kapur, S., Kleinman, A., Ogunniyi, A., … Walport, M. (2011). Grand challenges in global mental health. *Nature*, *475*(7354), Article 7354. https://doi.org/10.1038/475027a

Collins, S. E. (2016). Associations Between Socioeconomic Factors and Alcohol Outcomes. *Alcohol Research : Current Reviews*, *38*(1), 83–94.

Comaroff, J. L., & Comaroff, J. (2001). On Personhood: An Anthropological Perspective from Africa. *Social Identities*, *7*(2), 267–283. https://doi.org/10.1080/13504630120065310

Connell, R. (2014). The study of masculinities. *Qualitative Research Journal*, *14*(1), 5–15. https://doi.org/10.1108/QRJ-03-2014-0006

Cooper, S. (2016a). Global mental health and its critics: Moving beyond the impasse. *Critical Public Health*, *26*(4), 355–358. https://doi.org/10.1080/09581596.2016.1161730

Cooper, S. (2016b). Research on help-seeking for mental illness in Africa: Dominant approaches and possible alternatives. *Transcultural Psychiatry*, *53*(6), 696–718. https://doi.org/10.1177/1363461515622762

Cox, N., & Webb, L. (2015). Poles apart: Does the export of mental health expertise from the Global North to the Global South represent a neutral relocation of knowledge and practice? *Sociology of Health & Illness*, *37*(5), 683–697. https://doi.org/10.1111/1467-9566.12230

Craze, J., & Marko, F. D. (2022, January 6). Death by Peace: How South Sudan’s Peace Agreement Ate the Grassroots. *African Arguments*. https://africanarguments.org/2022/01/death-by-peace-how-south-sudans-peace-agreement-ate-the-grassroots/

Crazzolara, J. P. (1938). *A Study of the Acooli Language, Grammar and Vocabulary.* Oxford University Press.

Cretney, R. (2014). Resilience for Whom? Emerging Critical Geographies of Socio-ecological Resilience: Resilience of What, for Whom? *Geography Compass*, *8*(9), 627–640. https://doi.org/10.1111/gec3.12154

Das, J., Do, Q.-T., Friedman, J., McKenzie, D., & Scott, K. (2007). Mental health and poverty in developing countries: Revisiting the relationship. *Social Science & Medicine (1982)*, *65*(3), 467–480. https://doi.org/10.1016/j.socscimed.2007.02.037

Das, V. (2004). *Critical events: An anthropological perspective on contemporary India* (6. impr). Oxford Univ. Press.

Das, V. (2007). *Life and words: Violence and the descent into the ordinary*. University of California Press.

Das, V. (2015). *Affliction: Health, disease, poverty* (First edition). Fordham University Press.

Das, V., Jackson, M., Kleinman, A., & Singh, B. (Eds.). (2014). *The ground between: Anthropologists engage philosophy*. Duke University Press.

Davis, E. A. (2018). Global Side Effects: Counter-Clinics in Mental Health Care. *Medical Anthropology*, *37*(1), 1.

Davis, O., & Geiger, B. B. (2017). Did Food Insecurity rise across Europe after the 2008 Crisis? An analysis across welfare regimes. *Social Policy and Society*, *16*(3), 343–360. https://doi.org/10.1017/S1474746416000166

Dawson, K. S., Bryant, R. A., Harper, M., Kuowei Tay, A., Rahman, A., Schafer, A., & van Ommeren, M. (2015). Problem Management Plus (PM+): A WHO transdiagnostic psychological intervention for common mental health problems. *World Psychiatry*, *14*(3), 354–357. https://doi.org/10.1002/wps.20255

Dayabandara, M., Hanwella, R., Ratnatunga, S., Seneviratne, S., Suraweera, C., & de Silva, V. A. (2017). Antipsychotic-associated weight gain: Management strategies and impact on treatment adherence. *Neuropsychiatric Disease and Treatment*, *13*, 2231–2241. https://doi.org/10.2147/NDT.S113099

De Vos, J. (2011). The psychologization of humanitarian aid: Skimming the battlefield and the disaster zone. *History of the Human Sciences*, *24*(3), 103–122. https://doi.org/10.1177/0952695111398572

Dean, M. (2010). *Governmentality: Power and rule in modern society* (2nd ed). SAGE.

DelVecchio-Good, M.-J. (2010). Trauma In Postconflict Aceh And Psychopharmaceuticals As A Medium Of Exchange. In J. H. Jenkins (Ed.), *Pharmaceutical self: The global shaping of experience in an age of psychopharmacology / edited by Janis H. Jenkins.* School for Advanced Research Press.

Desjarlais, R., & Throop, C. J. (2011). Phenomenological Approaches in Anthropology. *Annual Review of Anthropology*, *4*, 87–102.

Desmond, M. (2016). *Evicted: Poverty and Profit in the American City*. Crown Publishing Group.

Díaz Letelier, N. (2022). Trapped Present, or the Capture(d) Affects of Imprisonment. *Current Anthropology*, *63*(2), 225–231. https://doi.org/10.1086/719787

Dolan, C. (2002). Collapsing Masculinities and Weak States—A case study of northern Uganda. In F. Cleaver (Ed.), *Masculinities Matter!: Men, Gender and Development* (1st edition, pp. 57–84). Zed Books.

Dolan, C. (2009). *Social torture: The case of northern Uganda, 1986-2006*. Berghahn Books.

Dryer-Peterson, S., & Hovil, L. (2004). *Local integration as a durable solution: Refugees, host populations and education in Uganda* (No. 93; New Issues in Refugee Research, p. 29). UNHCR. https://www.unhcr.org/uk/media/26585

Duffield, M. (2012). Challenging environments: Danger, resilience and the aid industry. *Security Dialogue*, *43*(5), 475–492.

Duffield, M. (2013). *Disaster-Resilience in the Network Age Access-Denial and the Rise of Cyber-Humanitarianism* (DIIS Working Paper 2013:23; p. 33). Danish Institute for International Studies. https://www.jstor.org/stable/resrep13344

Duffield, M. (2015). Resilience and abandonment. *Resilience*, *3*(2), 137–140. https://doi.org/10.1080/21693293.2015.1022990

Easton-Calabria, E., & Herson, M. (2020). In praise of dependencies: Dispersed dependencies and displacement. *Disasters*, *44*(1), 44–62. https://doi.org/10.1111/disa.12366

Easton-Calabria, E., & Omata, N. (2018). Panacea for the refugee crisis? Rethinking the promotion of 'self-reliance' for refugees. *Third World Quarterly*, *39*(8), 1458–1474. https://doi.org/10.1080/01436597.2018.1458301

Echeverri, C., Le Roy, J., Worku, B., & Ventevogel, P. (2018). Mental health capacity building in refugee primary health care settings in Sub-Saharan Africa: Impact, challenges and gaps. *Global Mental Health*, *5*, e28. https://doi.org/10.1017/gmh.2018.19

Ecks, S. (2014). *Eating drugs: Psychopharmaceutical pluralism in India*. New York University Press.

Ecks, S. (2017). The Public and Private Lives of Psychopharmaceuticals in the Global South. In J. Davies (Ed.), *The Sedated Society: The Causes and Harms of our Psychiatric Drug Epidemic* (pp. 249–269). Springer International Publishing. https://doi.org/10.1007/978-3-319-44911-1_10

Ecks, S., & Basu, S. (2014). 'We always live in fear': Antidepressant prescriptions by unlicensed doctors in India. *Culture, Medicine and Psychiatry*, *38*(2), 197–216. https://doi.org/10.1007/s11013-014-9368-9

Eisenbruch, M. (1991). From post-traumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees. *Social Science & Medicine*, *33*(6), 673–680. https://doi.org/10.1016/0277-9536(91)90021-4

Elizabeth Yarris, K., & Ponting, C. (2019). Moral Matters: Schizophrenia and Masculinity in Mexico. *Ethos*, *47*(1), 35–53. https://doi.org/10.1111/etho.12226

El-Shaarawi, N. (2015). Living an Uncertain Future: Temporality, Uncertainty, and Well-Being among Iraqi Refugees in Egypt. *Social Analysis*, *59*(1). https://doi.org/10.3167/sa.2015.590103

El-Shaarawi, N. (2021). A transit state: The ambivalences of the refugee resettlement process for Iraqis in Cairo. *American Ethnologist*, *48*(4), 404–417. https://doi.org/10.1111/amet.13048

Epping-Jordan, J. E., van Ommeren, M., Ashour, H. N., Maramis, A., Marini, A., Mohanraj, A., Noori, A., Rizwan, H., Saeed, K., Silove, D., Suveendran, T., Urbina, L., Ventevogel, P., & Saxena, S. (2015). Beyond the crisis: Building back better mental health care in 10 emergency-affected areas using a longer-term perspective. *International Journal of Mental Health Systems*, *9*(1), 15. https://doi.org/10.1186/s13033-015-0007-9

Epule, T. E., Dhiba, D., Etongo, D., Peng, C., & Lepage, L. (2021). Identifying maize yield and precipitation gaps in Uganda. *SN Applied Sciences*, *3*(5), 537. https://doi.org/10.1007/s42452-021-04532-5

Eriksen, T. H. (2010). *Ethnicity and Nationalism: Anthropological Perspectives* (V. Amit & J. P. Mitchell, Eds.). Pluto Press. https://doi.org/10.2307/j.ctt183h0h1

Esponda, G. M., Larrieta, J., Hartman, S., Cuevas, F. R., Cohen, A., & Kakuma, R. (2022). What factors influence engagement with primary mental health care services? A qualitative study of service user perspectives in rural communities of Mexico. *SSM - Mental Health*, *2*, 100125. https://doi.org/10.1016/j.ssmmh.2022.100125

Esposito, L., & Perez, F. M. (2014). Neoliberalism and the Commodification of Mental Health. *Humanity & Society*, *38*(4), 414–442. https://doi.org/10.1177/0160597614544958

Etkin, N. L. (1992). “Side Effects”: Cultural Constructions and Reinterpretations of Western Pharmaceuticals. *Medical Anthropology Quarterly*, *6*(2), 99–113. https://doi.org/10.1525/maq.1992.6.2.02a00010

Fanon, F. (1964). The North African Syndrome. In F. Maspero (Ed.), & H. Chevalier (Trans.), *Toward the African Revolution*. Grove Press.

FAO, & OPM. (2018). *Food security, resilience and well-being analysis of refugees and host communities in northern Uganda* (FAO Resilience Analysis Report No. 12; Analysing Resilience for Targeting and Action, p. 78). FAO. https://www.resiliencelinks.org/system/files/documents/2019-08/i9708en.pdf

Farmer, P. (1997). On Suffering and Structural Violence. In A. Kleinman, V. Das, & M. M. Lock (Eds.), *Social Suffering* (First Edition, pp. 261–283). University of California Press.

Farmer, P. (2004a). An Anthropology of Structural Violence. *Current Anthropology*, *45*(3), 305–325. https://doi.org/10.1086/382250

Farmer, P. (2004b). *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. University of California Press.

Farmer, P. (2020). *Fevers, feuds, and diamonds: Ebola and The Ravages of History* (First edition). Farrar, Straus and Giroux.

Farooq, S., & Naeem, F. (2014). Tackling nonadherence in psychiatric disorders: Current opinion. *Neuropsychiatric Disease and Treatment*, *10*, 1069–1077. https://doi.org/10.2147/NDT.S40777

Fassin, D. (2011). *Humanitarian Reason: A Moral History of the Present*. University of California Press.

Fassin, D., & Rechtman, R. (2009). *The Empire of Trauma: An Inquiry Into the Condition of Victimhood*. Princeton University Press.

Fast, D., Bukusi, D., & Moyer, E. (2020). The knife's edge: Masculinities and precarity in East Africa. *Social Science & Medicine*, *258*, 113097. https://doi.org/10.1016/j.socscimed.2020.113097

Fathi, M. (2021). 'My life is on hold': Examining home, belonging and temporality among migrant men in Ireland. *Gender, Place & Culture*, 1–19. https://doi.org/10.1080/0966369X.2021.1916445

Felli, R. (2016). The World Bank's Neoliberal Language of Resilience. In S. Soederberg (Ed.), *Research in Political Economy* (Vol. 31, pp. 267–295). Emerald Group Publishing Limited. https://doi.org/10.1108/S0161-723020160000031014

Fernando, G. A. (2012). The roads less traveled: Mapping some pathways on the global mental health research roadmap. *Transcultural Psychiatry*, *49*(3–4), 396–417. https://doi.org/10.1177/1363461512447137

Fernando, S. (2011). A 'global' mental health program or markets for Big Pharma? *Open Mind*, 22.

Fernando, S. (2014). Globalization of psychiatry – A barrier to mental health development. *International Review of Psychiatry*, *26*(5), 551–557. https://doi.org/10.3109/09540261.2014.920305

Fernstrom, M. H., & Kupfer, D. J. (1988). Antidepressant-induced weight gain: A comparison study of four medications. *Psychiatry Research*, *26*(3), 265–271. https://doi.org/10.1016/0165-1781(88)90120-5

Fiddian-Qasmiyeh, E. (2016). On the threshold of statelessness: Palestinian narratives of loss and erasure. *Ethnic and Racial Studies*, *39*(2), 301–321. https://doi.org/10.1080/01419870.2016.1105997

Fine, S. L., Kane, J. C., Spiegel, P. B., Tol, W. A., & Ventevogel, P. (2022). Ten years of tracking mental health in refugee primary health care settings: An updated analysis of data from UNHCR's Health Information System (2009–2018). *BMC Medicine*, *20*(1), 183. https://doi.org/10.1186/s12916-022-02371-8

Finnström, S. (2001). In and Out of Culture: Fieldwork in War-torn Uganda. *Critique of Anthropology*, *21*(3), 247–258. https://doi.org/10.1177/0308275X0102100304

Finnström, S. (2008). *Living with Bad Surroundings: War, History, and Everyday Moments in Northern Uganda*. Duke University Press.

Finnström, S. (2015). War Stories and Troubled Peace: Revisiting Some Secrets of Northern Uganda. *Current Anthropology*, *56*(S12), S222–S230. https://doi.org/10.1086/683270

Fisher, J., & Leonardi, C. (2020). Insecurity and the invisible: The challenge of spiritual (in)security. *Security Dialogue*. https://doi.org/10.1177/0967010620973540

Flaherty, M. G. (2020). The Lathe of Time: Some Principles of Temporal Agency. In M. G. Flaherty, L. Meinert, & A. L. Dalsgård (Eds.), *Time Work: Studies of Temporal Agency*. Berghahn Books.

Flaherty, M. G., Meinert, L., & Dalsgård, A. L. (2020). *Time Work: Studies of Temporal Agency*. Berghahn Books.

Food and Agriculture Organization of the United Nations (FAO). (2022). *Understanding poverty and food insecurity at the household level*. FAO. https://doi.org/10.4060/cc2993en

Foucault, M. (2008). *The birth of biopolitics: Lectures at the Collège de France, 1978-79*. Palgrave Macmillan.

Frederiksen, M. D., & Dalsgård, A. L. (2014). Introduction: Time Objectified. In A. L. Dalsgård, M. D. Frederiksen, S. Højlund, & L. Meinert (Eds.), *Ethnographies of Youth and Temporality: Time Objectified* (pp. 1–22). Temple University Press. https://doi.org/10.2307/j.ctvrdf2bg

Freeman, M. (2022). The World Mental Health Report: Transforming mental health for all. *World Psychiatry*, *21*(3), 391–392. https://doi.org/10.1002/wps.21018

Fuchs, T. (2013). Temporality and psychopathology. *Phenomenology and the Cognitive Sciences*, *12*(1), 75–104. https://doi.org/10.1007/s11097-010-9189-4

Funk, M., Saraceno, B., Drew, N., & Faydi, E. (2008). Integrating mental health into primary healthcare. *Mental Health in Family Medicine*, *5*(1), 5–8.

Gatrell, P. (2015). *The Making of the Modern Refugee*. Oxford University Press.

Giordano, C. (2014). *Migrants in Translation: Caring and the Logics of Difference in Contemporary Italy*.

Gómez-Carrillo, A., Lencucha, R., Faregh, N., Veissière, S., & Kirmayer, L. J. (2020). Engaging culture and context in mhGAP implementation: Fostering reflexive deliberation in practice. *BMJ Global Health*, *5*(9), e002689. https://doi.org/10.1136/bmjgh-2020-002689

Good, B. J. (2010). The Complexities of psychopharmaceutical hegemonies in Indonesia. In J. H. Jenkins (Ed.), *Pharmaceutical self: The global shaping of experience in an age of psychopharmacology / edited by Janis H. Jenkins.* (pp. 117–144). School for Advanced Research Press.

Good, B. J. (2012). Theorizing the 'subject' of medical and psychiatric anthropology*. *Journal of the Royal Anthropological Institute*, *18*(3), 515–535. https://doi.org/10.1111/j.1467-9655.2012.01774.x

Gorur, A., & Carstensen, N. (2016). Community Self-protection. In H. Willmot, R. Mamiya, S. Sheeran, & M. Weller (Eds.), *Protection of Civilians* (pp. 409–427).

Government of Uganda (2018). *Mental Health Act, 2018*.

Government of Uganda, & United Nations High Commissioner for Refugees (UNHCR). (2022). *Uganda—Refugee Statistics August 2022—Palabek*. https://data.unhcr.org/en/documents/details/95613

Government of Uganda, United Nations High Commissioner for Refugees (UNHCR), UNICEF, & World Food Programme (WFP). (2018). *Food Security and Nutrition Assessment in Refugee Settlements Final Report, Data Collected: October 2017 - Uganda | ReliefWeb*. https://reliefweb.int/report/uganda/food-security-and-nutrition-assessment-refugee-settlements-final-report-data-collected

Grabska, K., & Fanjoy, M. (2015). "And When I Become a Man": Translocal Coping with Precariousness and Uncertainty among Returnee Men in South Sudan. *Social Analysis*, *59*(1). https://doi.org/10.3167/sa.2015.590105

Green, A. (2018, December 10). Uganda Went From Being a Model of Refugee Response to a Cautionary Tale. *World Politics Review*. https://www.worldpoliticsreview.com/with-its-open-door-policy-toward-refugees-uganda-has-gone-from-model-to-cautionary-tale/

Griffiths, M. (2014). Out of time: The temporal uncertainties of refused asylum seekers and immigration detainees. *Journal of Ethnic and Migration Studies*, *40*(12), 1991–2009.

Gumisiriza, P. (2018). *Challenges and Emerging Issues Affecting the Management of Refugees in Uganda* (SSRN Scholarly Paper No. 3477396). https://papers.ssrn.com/abstract=3477396

Gupta, A., & Ferguson, J. (1997). Discipline and Practice: 'The Field' as Site, Method, and Location in Anthropology. In A. Gupta & J. Ferguson (Eds.), *Anthropological locations: Boundaries and grounds of a field science* (pp. 1–46). University of California Press.

Haas, B. M. (2017). Citizens-in-Waiting, Deportees-in-Waiting: Power, Temporality, and Suffering in the U.S. Asylum System. *Ethos*, *45*(1), 75–97. https://doi.org/10.1111/etho.12150

Hage, G. (2005). A not so multi-sited ethnography of a not so imagined community. *Anthropological Theory*, *5*(4), 463–475. https://doi.org/10.1177/1463499605059232

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed). Routledge.

Hammond, L., Sturridge, C., Ronald, K., Owiso, M., Mahdi, M., Manji, F., & Osman, A. A. (2020). *Comprehensive Refugee Responses in the Horn of Africa:* (p. 83). https://blogs.soas.ac.uk/ref-hornresearch/files/2020/03/CRRF-report.pdf

Han, C. (2012). *Life in debt: Times of care and violence in neoliberal Chile*. University of California Press.

Hansen, R. (2018). The Comprehensive Refugee Response Framework: A Commentary. *Journal of Refugee Studies*, *31*(2), 131–151. https://doi.org/10.1093/jrs/fey020

Hardon, A. (2002). Mothers and children: The efficacies of drugs. In S. R. Whyte, S. van der Geest, & A. Hardon, *Social lives of medicines* (pp. 23–36). Cambridge University Press.

Haroz, E. E., Nguyen, A. J., Lee, C. I., Tol, W. A., Fine, S. L., & Bolton, P. (2020). What works in psychosocial programming in humanitarian contexts in low- and middle-income countries: A systematic review of the evidence. *Intervention*, *18*(1), 3. https://doi.org/10.4103/INTV.INTV_6_19

Harrell-Bond, B. E. (1986). *Imposing aid: Emergency assistance to refugees*. Oxford University Press.

Hartonen, V. R., Väisänen, P., Karlsson, L., & Pöllänen, S. (2021). A stage of limbo: A meta-synthesis of refugees' liminality. *Applied Psychology*, 1–36. https://doi.org/10.1111/apps.12349

Haslanger, S. (2023). Systemic and Structural Injustice: Is There a Difference? *Philosophy*, *98*(1), 1–27. https://doi.org/10.1017/S0031819122000353

Haushofer, J., Mudida, R., & Shapiro, J. (2021). *The Comparative Impact of Cash Transfers and a Psychotherapy Program on Psychological and Economic Well-being* (SSRN Scholarly Paper No. 3759722). https://doi.org/10.2139/ssrn.3759722

Healy, D. (2006). The New Medical Oikumene. In A. Petryna, A. Lakoff, & A. Kleinman (Eds.), *Global pharmaceuticals ethics, markets, practices* (pp. 61–84). Duke University Press.

Heim, E., & Kohrt, B. A. (2019). Cultural Adaptation of Scalable Psychological Interventions: *Clinical Psychology in Europe*, *1*(4), Article 4. https://doi.org/10.32872/cpe.v1i4.37679

Hijazi, Z., Weissbecker, I., & Chammay, R. (2011). *The integration of mental health into primary health care in Lebanon*. *9*(3), 14.

Hilhorst, D. (2018). Classical humanitarianism and resilience humanitarianism: Making sense of two brands of humanitarian action. *Journal of International Humanitarian Action*, *3*(1), 15. https://doi.org/10.1186/s41018-018-0043-6

Hilhorst, D., & Jansen, B. J. (2010). Humanitarian Space as Arena: A Perspective on the Everyday Politics of Aid. *Development and Change*, *41*(6), 1117–1139. https://doi.org/10.1111/j.1467-7660.2010.01673.x

Hillel, R. S. (2023). Decolonising mental health interventions in the humanitarian system. *The Humanitarian Leader*, paper 032-2023. https://doi.org/10.21153/thl2023art1722

Hinton, D. E., & Good, B. (Eds.). (2016). *Culture and PTSD: Trauma in global and historical perspective*. University of Pennsylvania Press.

Ho, E. L.-E. (2021). Social geography I: Time and temporality. *Progress in Human Geography*, *45*(6), 1668–1677. https://doi.org/10.1177/03091325211009304

Hogerzeil, H. V. (1990). Emergency health kits. *The Lancet*, *336*(8724), 1194. https://doi.org/10.1016/0140-6736(90)92812-V

Holbraad, M. (2018). Steps Away from Moralism. In B. Kapferer & M. Gold, *Moral Anthropology: A Critique* (pp. 27–48). Berghahn Books.

Honwana, A. (2013). Changing patterns of intimacy among Young People in Africa. In U. Engel & M. J. Ramos (Eds.), *African Dynamics in a Multipolar World*. BRILL.

Honwana, A. (2014). Youth, Waithood, and Protest Movements in Africa. *African Dynamics in a Multipolar World: 5th European Conference on African Studies — Conference Proceedings*, 2428–2447.

Hopwood, J. (2022a). An inherited animus to communal land: The mechanisms of coloniality in land reform agendas in Acholiland, Northern Uganda. *Critical African Studies*, *14*(1), 38–54. https://doi.org/10.1080/21681392.2021.1931383

Hopwood, J. (2022b). *Searching for land, finding people: Intimate governance and subalternity in Acholi, northern Uganda*. Ghent University.

Hordge-Freeman, E. (2018). “Bringing Your Whole Self to Research”: The Power of the Researcher’s Body, Emotions, and Identities in Ethnography. *International Journal of Qualitative Methods*, *17*(1), 1609406918808862. https://doi.org/10.1177/1609406918808862

Horst, C., & Grabska, K. (2015). Flight and Exile—Uncertainty in the Context of Conflict-Induced Displacement. *Social Analysis*, *59*(1), 1–18. https://doi.org/10.3167/sa.2015.590101

Horwitz, A. V., & Wakefield, J. C. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. Oxford University Press.

Hovil, L. (2007). Self-settled Refugees in Uganda: An Alternative Approach to Displacement? *Journal of Refugee Studies*, *20*(4), 599–620. https://doi.org/10.1093/jrs/fem035

Hovil, L., & Werker, E. (2001). REFUGEES IN ARUA DISTRICT: A HUMAN SECURITY ANALYSIS. *Refugee Law Project*, *Working Paper*(3).

Howell, A. (2011). *Madness in International Relations: Psychology, Security, and the Global Governance of Mental Health*. Routledge.

Howell, A. (2015). Resilience as Enhancement: Governmentality and Political Economy beyond 'Responsibilisation'. *Politics*, *35*(1), 67–71. https://doi.org/10.1111/1467-9256.12080

Human Rights Watch. (2018). South Sudan: Events of 2017. In *World Report 2018*. https://www.hrw.org/world-report/2018/country-chapters/south-sudan

Human Rights Watch. (2021). Uganda: Events of 2021. In *World Report 2022*. https://www.hrw.org/world-report/2022/country-chapters/uganda

Human Rights Watch. (2023a). South Sudan: Events of 2022. In *World Report 2023*. https://www.hrw.org/world-report/2023/country-chapters/south-sudan

Human Rights Watch. (2023b, March 9). Uganda: New Anti-Gay Bill Further Threatens Rights. *Human Rights Watch*. https://www.hrw.org/news/2023/03/09/uganda-new-anti-gay-bill-further-threatens-rights

Humbert, C., & Joseph, J. (2019). Introduction: The politics of resilience: problematising current approaches. *Resilience*, *7*(3), 215–223. https://doi.org/10.1080/21693293.2019.1613738

Hunter, M. (2010). *Love in the Time of AIDS: Inequality, Gender, and Rights in South Africa*. Indiana University Press.

Hunter, M. (2005). Cultural politics and masculinities: Multiple-partners in historical perspective in KwaZulu-Natal. *Culture, Health & Sexuality*, *7*(3), 209–223. https://doi.org/10.1080/13691050412331293458

Hutchinson, S. E., & Jok, J. M. (2002). Gendered Violence and the Militarization of Ethnicity: A Case Study from South Sudan. In R. P. Werbner (Ed.), *Postcolonial subjectivities in Africa* (pp. 84–107). Zed Books.

Hutchinson, S. E., & Pendle, N. R. (2015). Violence, legitimacy, and prophecy: Nuer struggles with uncertainty in South Sudan. *American Ethnologist*, *42*(3), 415–430. https://doi.org/10.1111/amet.12138

Hyndman, J., & Giles, W. (2011). Waiting for what? The feminization of asylum in protracted situations. *Gender, Place & Culture*, *18*(3), 361–379. https://doi.org/10.1080/0966369X.2011.566347

IASC. (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* [Data set]. American Psychological Association. https://doi.org/10.1037/e518422011-002

Ibrahim, A W, Pindar, S K, Yerima, M M, Rabbebe, I B, Shehu, S, Garkuwa, H A, Bashir, I Y, Wakil, M A, Yahya, & S J. (2015). Medication-related factors of non adherence among patients with schizophrenia and bipolar disorder: Outcome of a cross-sectional survey in Maiduguri, North-eastern Nigeria. *Journal of Neuroscience and Behavioral Health*, *7*(5), 31–39. https://doi.org/10.5897/JNBH2015.0128

Ibrahim, B. (2021). *Uprooting, Trauma, and Confinement: Psychiatry in Refugee Camps, 1945 - 1993*. University of Glasgow.

Ibreck, R. (2023). Protecting Women from Violence in the United Nations Protection of Civilians Sites, South Sudan? *Journal of Intervention and Statebuilding*, *0*(0), 1–20. https://doi.org/10.1080/17502977.2023.2215604

Iemmi, V. (2022). Establishing political priority for global mental health: A qualitative policy analysis. *Health Policy and Planning*, *37*(8), 1012–1024. https://doi.org/10.1093/heapol/czac046

Ilcan, S., Oliver, M., & Connoy, L. (2015). *Humanitarian Assistance and the Politics of Self-Reliance Uganda's Nakivale Refugee Settlement* (No. 86; CIGI Papers). Centre for International Governance Innovation (CIGI). https://policycommons.net/artifacts/1451257/humanitarian-assistance-and-the-politics-of-self-reliance-ugandas-nakivale-refugee-settlement/2083064/

Ilcan, S., & Rygiel, K. (2015). "Resiliency Humanitarianism": Responsibilizing Refugees through Humanitarian Emergency Governance in the Camp. *International Political Sociology*, *9*(4), 333–351. https://doi.org/10.1111/ips.12101

Ingleby, D. (2014). How 'evidence-based' is the Movement for Global Mental Health? *Disability and the Global South*, *1*(2), 203–226.

International Refugee Rights Initiative (IRRI). (2018). *Uganda's refugee policies: The history, the politics, the way forward* (Rights in Exile, p. 16). http://refugee-rights.org/wp-content/uploads/2018/10/IRRI-Uganda-policy-paper-October-2018-Paper.pdf

International Refugee Rights Initiative (IRRI). (2019). *Understanding conflict dynamics around refugee settlements in northern Uganda*.

Introduction: In the Event—Toward an Anthropology of Generic Moments. (2015). In L. Meinert & B. Kapferer, *In the Event: Toward an Anthropology of Generic Moments* (pp. 1–28). Berghahn Books.

Jackson, M. (1989). *Paths Toward a Clearing* (First Edition). John Wiley & Sons.

Jackson, M. (1998). *Minima Ethnographica: Intersubjectivity and the Anthropological Project*. University of Chicago Press. https://press.uchicago.edu/ucp/books/book/chicago/M/bo3626084.html

Jackson, M. (2002). *The politics of storytelling: Violence, transgression, and intersubjectivity*. Museum Tusculanum Press, University of Copenhagen ; Distributor USA & Canada, International Specialized Book Services.

Jackson, M. (2005). *Existential anthropology: Events, exigencies, and effects*. Berghahn Books.

Jain, S., & Jadhav, S. (2009). Pills that Swallow Policy: Clinical Ethnography of a Community Mental Health Program in Northern India. *Transcultural Psychiatry*, *46*(1), 60–85. https://doi.org/10.1177/1363461509102287

Jain, S., & Orr, D. M. R. (2016). Ethnographic perspectives on global mental health. *Transcultural Psychiatry*, *53*(6), 685–695. https://doi.org/10.1177/1363461516679322

James, E. C. (2010). Ruptures, rights, and repair: The political economy of trauma in Haiti. *Social Science & Medicine*, *70*(1), 106–113. https://doi.org/10.1016/j.socscimed.2009.09.040

Janmyr, M. (2014). Recruiting Internally Displaced Persons into Civil Militias: The Case of Northern Uganda. *Nordic Journal of Human Rights*, *32*(3), 199–219. https://doi.org/10.1080/18918131.2014.937203

Jansen, S., White, R., Hogwood, J., Jansen, A., Gishoma, D., Mukamana, D., & Richters, A. (2015). The "treatment gap" in global mental health reconsidered: Sociotherapy for collective trauma in Rwanda. *European Journal of Psychotraumatology*, *6*(1), 28706. https://doi.org/10.3402/ejpt.v6.28706

Jefferson, A. M., & Buch Segal, L. (2019). The Confines of Time – On the Ebbing Away of Futures in Sierra Leone and Palestine. *Ethnos*, *84*(1), 96–112. https://doi.org/10.1080/00141844.2018.1548497

Jefferson, A., Turner, S., & Jensen, S. (2019). Introduction: On Stuckness and Sites of Confinement. *Ethnos*, *84*(1), 1–13. https://doi.org/10.1080/00141844.2018.1544917

Jenkins, J. H. (2015a). *Extraordinary Conditions: Culture and Experience in Mental Illness*.

Jenkins, J. H. (2015b). *Extraordinary conditions: Culture and experience in mental illness* (First edition). University of California Press.

Jenkins, J. H., & Kozelka, E. (2017). Global Mental Health and Psychopharmacology in Precarious Ecologies: Anthropological Considerations for Engagement and Efficacy. In R. G. White, S. Jain, D. M. R. Orr, & U. M. Read (Eds.), *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health* (pp. 151–168). Palgrave Macmillan UK. https://doi.org/10.1057/978-1-137-39510-8_8

Jensen, S. (2014). Stunted future: Buryong among young men in Manila. In A.-L. Dalsgaard, M. Demant, S. Højlund, & Lotte Meinert (Eds.), *Ethnographies of Youth and Temporality*. Temple University Press.

Johnson, D. H. (2014). Briefing: The crisis in South Sudan. *African Affairs*, *113*(451), 300–309. https://doi.org/10.1093/afraf/adu020

Johnson, H. L. (2011). Click to Donate: Visual images, constructing victims and imagining the female refugee. *Third World Quarterly*, *32*(6), 1015–1037. https://doi.org/10.1080/01436597.2011.586235

Jones, A. D. (2017). Food Insecurity and Mental Health Status: A Global Analysis of 149 Countries. *American Journal of Preventive Medicine*, *53*(2), 264–273. https://doi.org/10.1016/j.amepre.2017.04.008

Jones, L., Asare, J. B., El Masri, M., Mohanraj, A., Sherief, H., & van Ommeren, M. (2009). Severe mental disorders in complex emergencies. *The Lancet*, *374*(9690), 654–661. https://doi.org/10.1016/S0140-6736(09)61253-8

Jones, L., & Ventevogel, P. (2021). From exception to the norm: How mental health interventions have become part and parcel of the humanitarian response. *World Psychiatry*, *20*(1), 2–3. https://doi.org/10.1002/wps.20808

Joseph, J. (2013). Resilience as embedded neoliberalism: A governmentality approach. *Resilience*, *1*(1), 38–52. https://doi.org/10.1080/21693293.2013.765741

Kaiser, B. N., Haroz, E. E., Kohrt, B. A., Bolton, P. A., Bass, J. K., & Hinton, D. E. (2015). “Thinking too much”: A Systematic review of a common idiom of distress. *Social Science & Medicine (1982)*, *147*, 170. https://doi.org/10.1016/j.socscimed.2015.10.044

Kaiser, T. (2000). *UNHCR's withdrawal from Kiryandongo: Anatomy of a handover* (Working Paper No. 32; New Issues in Refugee Research, p. 26). UNHCR. https://www.unhcr.org/in/media/unhcrs-withdrawal-kiryandongo-anatomy-handover-tania-kaiser

Kaiser, T. (2002). Unhcr,s Withdrawal from Kiryandongo: Anatomy of a Handover. *Refugee Survey Quarterly*, *21*(1/2), 201–227.

Kaiser, T. (2005). Participating in Development? Refugee protection, politics and developmental approaches to refugee management in Uganda. *Third World Quarterly*, *26*(2), 351–367. https://doi.org/10.1080/0143659042000339155

Kaiser, T. (2006a). Between a camp and a hard place: Rights, livelihood and experiences of the local settlement system for long-term refugees in Uganda. *The Journal of Modern African Studies*, *44*(4), 597–621. https://doi.org/10.1017/S0022278X06002102

Kaiser, T. (2006b). Songs, Discos and Dancing in Kiryandongo, Uganda. *Journal of Ethnic and Migration Studies*, *32*(2), 183–202. https://doi.org/10.1080/13691830500487399

Kaiser, T. (2010). Dispersal, division and diversification: Durable solutions and Sudanese refugees in Uganda. *Journal of Eastern African Studies*, *4*(1), 44–60. https://doi.org/10.1080/17531050903550116

Kane, J. C., Ventevogel, P., Spiegel, P., Bass, J. K., van Ommeren, M., & Tol, W. A. (2014). Mental, neurological, and substance use problems among refugees in primary health care: Analysis of the Health Information System in 90 refugee camps. *BMC Medicine*, *12*, 228. https://doi.org/10.1186/s12916-014-0228-9

Kapferer, B., & Gold, M. (2018). *Moral Anthropology: A Critique*. Berghahn Books.

Karasz, A., Khurshid, A., Maier, W., Ragavan, S., & Ryder, A. G. (2022). When distress becomes disease: The social context and uses of disease attributions in common mental disorder. *SSM - Qualitative Research in Health*, 100171. https://doi.org/10.1016/j.ssmqr.2022.100171

Kasparek, B. (2016). Routes, Corridors, and Spaces of Exception: Governing Migration and Europe. *Near Futures Online*, *1 "Europe at a Crossroads"*. nearfuturesonline.org/ the-life-and-time-of-the-european-consolidationstate.html

Keller, R. C. (2007). Taking Science to the Colonies: Psychiatric Innovation in France and North Africa. In S. Mahone & M. Vaughan (Eds.), *Psychiatry and Empire* (pp. 17–40). Palgrave Macmillan UK. https://doi.org/10.1057/9780230593244_2

Kerbage, H., & Marranconi, F. (2017). Mental Health and Psychosocial Support Services (MHPSS) for Syrian Refugees in Lebanon: Towards a Public Health Approach Beyond Diagnostic Categories. *European Scientific Journal, ESJ*. https://doi.org/10.19044/esj.2017.v13n10p%p

Keys, H. M., & Kaiser, B. N. (2017). Language, Measurement, and Structural Violence: Global Mental Health Case Studies from Haiti and the Dominican Republic. In R. G. White, S. Jain, D. M. R. Orr, & U. M. Read (Eds.), *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health* (pp. 589–607). Palgrave Macmillan UK. https://doi.org/10.1057/978-1-137-39510-8_28

Kibreab, G. (1993). The Myth of Dependency among Camp Regugees in Somalia 1979-1989. *Journal of Refugee Studies*, *6*(4), 321–349.

Kidron, C. A., & Kirmayer, L. J. (2019a). Global Mental Health and Idioms of Distress: The Paradox of Culture-Sensitive Pathologization of Distress in Cambodia. *Culture, Medicine, and Psychiatry*, *43*(2), 211–235. https://doi.org/10.1007/s11013-018-9612-9

Kidron, C. A., & Kirmayer, L. J. (2019b). Global Mental Health and Idioms of Distress: The Paradox of Culture-Sensitive Pathologization of Distress in Cambodia. *Culture, Medicine, and Psychiatry*, *43*(2), 211–235. https://doi.org/10.1007/s11013-018-9612-9

Kienzler, H. (2008). Debating war-trauma and post-traumatic stress disorder (PTSD) in an interdisciplinary arena. *Social Science & Medicine*, *67*(2), 218–227. https://doi.org/10.1016/j.socscimed.2008.03.030

Kienzler, H. (2019). Mental Health System Reform in Contexts of Humanitarian Emergencies: Toward a Theory of "Practice-Based Evidence". *Culture, Medicine, and Psychiatry*, *43*(4), 636–662. https://doi.org/10.1007/s11013-019-09641-w

Kienzler, H., & Pedersen, D. (2012). Strange but common bedfellows: The relationship between humanitarians and the military in developing psychosocial interventions for civilian populations affected by armed conflict. *Transcultural Psychiatry*, *49*(3–4), 492–518. https://doi.org/10.1177/1363461512447927

Kigozi, D. (2017, May 30). The Reality Behind Uganda's Refugee Model. *Refugees*. https://deeply.thenewhumanitarian.org/refugees/community/2017/05/30/the-reality-behind-ugandas-glowing-reputation

Kigozi, F. N., Kizza, D., Nakku, J., Ssebunnya, J., Ndyanabangi, S., Nakiganda, B., Lund, C., & Patel, V. (2016). Development of a district mental healthcare plan in Uganda. *The British Journal of Psychiatry*, *208*(s56), s40–s46. https://doi.org/10.1192/bjp.bp.114.153742

Kigozi, F. N., & Ssebunnya, J. (2009). Integration of mental health into primary health care in Uganda: Opportunities and challenges. *Mental Health in Family Medicine*, *6*(1), 37–42.

Kigozi, F., Ssebunnya, J., Kizza, D., Cooper, S., Ndyanabangi, S., & the Mental Health and Poverty Project. (2010). An overview of Uganda's mental health care system: Results from an assessment using the world health organization's assessment instrument for mental health systems (WHO-AIMS). *International Journal of Mental Health Systems*, *4*(1), 1. https://doi.org/10.1186/1752-4458-4-1

Kinyanda, E., Hjelmeland, H., Musisi, S., Kigozi, F., & Walugembe, J. (2005). Repetition of Deliberate Self-Harm as Seen in Uganda. *Archives of Suicide Research*, *9*(4), 333–344. https://doi.org/10.1080/13811110500182208

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164. https://doi.org/10.1177/1363461512444673

Kirmayer, L. J. (2020). Toward a Postcolonial Psychiatry: Uncovering the Structures of Domination in Mental Health Theory and Practice. *Philosophy, Psychiatry, & Psychology*, *27*(3), 267–271. https://doi.org/10.1353/ppp.2020.0033

Kirmayer, L. J., & Bhugra, D. (2009). Culture and mental illness: Social context and explanatory models. In I. M. Salloum & J. E. Mezzich, *Psychiatric Diagnosis: Challenges and Prospects* (pp. 29–40). John Wiley & Sons.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., Pottie, K., & for the Canadian Collaboration for Immigrant and Refugee Health (CCIRH). (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal*, *183*(12), E959–E967. https://doi.org/10.1503/cmaj.090292

Kirmayer, L. J., & Pedersen, D. (2014). Toward a new architecture for global mental health. *Transcultural Psychiatry*, *51*(6), 759–776. https://doi.org/10.1177/1363461514557202

Kirmayer, L. J., & Raikhel, E. (2009). Editorial: From Amrita to Substance D: Psychopharmacology, Political Economy, and Technologies of the Self. *Transcultural Psychiatry*, *46*(1), 5–15. https://doi.org/10.1177/1363461509102284

Kizza, D., Knizek, B. L., Kinyanda, E., & Hjelmeland, H. (2012). Men in despair: A qualitative psychological autopsy study of suicide in Northern Uganda. *Transcultural Psychiatry*, *49*(5), 696–717. https://doi.org/10.1177/1363461512459490

Klein, E., & Mills, C. (2017). Psy-expertise, therapeutic culture and the politics of the personal in development. *Third World Quarterly*, *38*(9), 1990–2008. https://doi.org/10.1080/01436597.2017.1319277

Kleinman, A. (Ed.). (1997). *Social Suffering* (First Edition). University of California Press.

Kleinman, A. (2006). *What really matters: Living a moral life amidst uncertainty and danger*. Oxford University Press.

Kleinman, A. (2009). Global mental health: A failure of humanity. *The Lancet*, *374*(9690), 603–604. https://doi.org/10.1016/S0140-6736(09)61510-5

Kleinman, A., & Benson, P. (2006). Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. *PLoS Medicine*, *3*(10), e294. https://doi.org/10.1371/journal.pmed.0030294

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, Illness, and Care. *Annals of Internal Medicine*, *88*(2), 251–258. https://doi.org/10.7326/0003-4819-88-2-251

Kleinman, A. M. (1977). Depression, somatization and the "new cross-cultural psychiatry". *Social Science & Medicine (1967)*, *11*(1), 3–9. https://doi.org/10.1016/0037-7856(77)90138-X

Kleist, N. (2010). Negotiating Respectable Masculinity: Gender and Recognition in the Somali Diaspora. *African Diaspora*, *3*(2), 185–206. https://doi.org/10.1163/187254610X526913

Kohrt, B. A., & Jallah, B. (2016). People, Praxis, and Power in Global Mental Health: Anthropology and the Experience Gap. In B. A. Kohrt & E. Mendenhall (Eds.), *Global Mental Health: Anthropological Perspectives* (pp. 259–276). Routledge. https://doi.org/10.4324/9781315428055

Kohrt, B. A., & Song, S. J. (2018). Who benefits from psychosocial support interventions in humanitarian settings? *The Lancet Global Health*, *6*(4), e354–e356. https://doi.org/10.1016/S2214-109X(18)30102-5

Kola, L. (2021). Beyond access to psychotropic medicines: Treatment coverage amid COVID-19. *The Lancet Psychiatry*, *8*(12), 1019–1021. https://doi.org/10.1016/S2215-0366(21)00431-4

Kovel, J. (2017). Therapy in late capitalism*. In R. Tweedy (Ed.), *The Political Self*. Routledge.

Krause, U. (2016). Limitations of development-oriented assistance in Uganda. *Forced Migration Review*, *52*(3), 51–53.

Krause, U. (2017). *Researching forced migration: Critical reflections on research ethics during fieldwork*. *123*, 39.

Krause, U., & Gato, J. (2017). Escaping humanitarian aid in camps? Rethinking the links between refugees' encampment, urban self-settlement, coping and peace. *Die Friedens-Warte*, *92*(1/2), 76–97.

Krause, U., & Schmidt, H. (2020). Refugees as Actors? Critical Reflections on Global Refugee Policies on Self-reliance and Resilience. *Journal of Refugee Studies*, *33*(1), 22–41. https://doi.org/10.1093/jrs/fez059

Kronick, R., Jarvis, G. E., & Kirmayer, L. J. (2021). Refugee mental health and human rights: A challenge for global mental health. *Transcultural Psychiatry*, *58*(2), 147–156. https://doi.org/10.1177/13634615211002690

Kuja-Kuja. (n.d.). *Kuja Kuja*. Idea Feed. https://alight.kujakuja.com/en/ideafeed?start=2023-06-14&end=2023-06-21&limit=50&page=1

Kumar, M., Rensburg, A. J. van, & Petersen, I. (2023). A call to review values, commitment, and outlook to mainstream mental health. *The Lancet Global Health*, *11*(7), e1005–e1006. https://doi.org/10.1016/S2214-109X(23)00273-5

Lakoff, A. (2005). *Pharmaceutical reason: Knowledge and value in global psychiatry*. Cambridge University Press.

Lancet Global Mental Health Group. (2007). Scale up services for mental disorders: A call for action. *The Lancet*, *370*(9594), 1241–1252. https://doi.org/10.1016/S0140-6736(07)61242-2

Lems, A. (2016). Placing Displacement: Place-making in a World of Movement. *Ethnos*, *81*(2), 315–337.

Leonardi, C. (2011). Paying 'buckets of blood' for the land: Moral debates over economy, war and state in Southern Sudan. *The Journal of Modern African Studies*, *49*(2), 215–240. https://doi.org/10.1017/S0022278X11000024

Leonardi, C. (2020). Patchwork States: The Localization of State Territoriality on the South Sudan–Uganda Border, 1914–2014*. *Past & Present*, *248*(1), 209–258. https://doi.org/10.1093/pastj/gtz052

Lewer, D., O'Reilly, C., Mojtabai, R., & Evans-Lacko, S. (2015). Antidepressant use in 27 European countries: Associations with sociodemographic, cultural and economic factors. *The British Journal of Psychiatry: The Journal of Mental Science*, *207*(3), 221–226. https://doi.org/10.1192/bjp.bp.114.156786

Li, T. (2007). *The Will to Improve*. Duke University Press. https://www.dukeupress.edu/the-will-to-improve/

Lie, J. H. S. (2020). The humanitarian-development nexus: Humanitarian principles, practice, and pragmatics. *Journal of International Humanitarian Action*, *5*(1), 18. https://doi.org/10.1186/s41018-020-00086-0

Littoz-Monnet, A. (2022). Exclusivity and Circularity in the Production of Global Governance Expertise: The Making of "Global Mental Health" Knowledge. *International Political Sociology*, olab035. https://doi.org/10.1093/ips/olab035

Logie, C. H., Okumu, M., Mwima, S., Hakiza, R., Chemutai, D., & Kyambadde, P. (2020). Contextual factors associated with depression among urban refugee and displaced youth in Kampala, Uganda: Findings from a cross-sectional study. *Conflict and Health*, *14*(1), 45. https://doi.org/10.1186/s13031-020-00289-7

Lovell, A. M., Read, U. M., & Lang, C. (2019). Genealogies and Anthropologies of Global Mental Health. *Culture, Medicine, and Psychiatry*, *43*(4), 519–547. https://doi.org/10.1007/s11013-019-09660-7

Luhrmann, T. (2007). Social Defeat and The Culture Of Chronicity: Or, Why Schizophrenia Does So Well Over There And So Badly Here. *Culture, Medicine and Psychiatry*, *31*, 135–172.

Luhrmann, T. M. (2016). Th e Culture of the Institutional Circuit in the United States. In T. M. Luhrmann & J. Marrow (Eds.), *Our Most Troubling Madness: Case Studies in Schizophrenia*

across Cultures (1st ed., pp. 153–167). University of California Press. https://www.jstor.org/stable/10.1525/j.ctt1f5g5ns

Luhrmann, T. M., Padmavati, R., Tharoor, H., & Osei, A. (2015). Differences in voice-hearing experiences of people with psychosis in the USA, India and Ghana: Interview-based study. *The British Journal of Psychiatry*, *206*(1), 41–44. https://doi.org/10.1192/bjp.bp.113.139048

Lund, C., Tomlinson, M., Silva, M. D., Fekadu, A., Shidhaye, R., Jordans, M., Petersen, I., Bhana, A., Kigozi, F., Prince, M., Thornicroft, G., Hanlon, C., Kakuma, R., McDaid, D., Saxena, S., Chisholm, D., Raja, S., Kippen-Wood, S., Honikman, S., … Patel, V. (2012). PRIME: A Programme to Reduce the Treatment Gap for Mental Disorders in Five Low- and Middle-Income Countries. *PLOS Medicine*, *9*(12), e1001359. https://doi.org/10.1371/journal.pmed.1001359

Lwambo, D. (2013). 'Before the war, I was a man': Men and masculinities in the Eastern Democratic Republic of Congo. *Gender & Development*, *21*(1), 47–66. https://doi.org/10.1080/13552074.2013.769771

Lwanga-Lunyiigo, S. (1993). *Uganda's long connection with the problem of refugees: From the Polish refugees of World War II to the present*. https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/5693

Maayan, L., & Correll, C. U. (2010). Management of Antipsychotic-Related Weight Gain. *Expert Review of Neurotherapeutics*, *10*(7), 1175–1200. https://doi.org/10.1586/ern.10.85

Mackenzie, C., McDowell, C., & Pittaway, E. (2007). Beyond 'Do No Harm': The Challenge of Constructing Ethical Relationships in Refugee Research. *Journal of Refugee Studies*, *20*(2), 299–319. https://doi.org/10.1093/jrs/fem008

Madut, K. K. (2020). Ethnic Mobilization, Armaments, and South Sudan's Quest for Sustainable Peace. *Peace Review*, *32*(2), 235–243. https://doi.org/10.1080/10402659.2020.1836448

Mahdiani, H., & Ungar, M. (2021). The Dark Side of Resilience. *Adversity and Resilience Science*, *2*(3), 147–155. https://doi.org/10.1007/s42844-021-00031-z

Mahone, S. (2006). The Psychology of Rebellion: Colonial Medical Responses to Dissent in British East Africa. *The Journal of African History*, *47*(2), 241–258. https://doi.org/10.1017/S0021853706001769

Mahone, S., & Vaughan, M. (2007). *Psychiatry and empire*. Palgrave Macmillan.

Malkki, L. (1992). National Geographic: The Rooting of Peoples and the Territorialization of National Identity among Scholars and Refugees. *Cultural Anthropology*, *7*(1), 24–44.

Malkki, L. H. (1995). Refugees and Exile: From 'Refugee Studies' to the National Order of Things. *Annual Review of Anthropology*, *24*, 495–523.

Malkki, L. H. (1996b). Speechless Emissaries: Refugees, Humanitarianism, and Dehistoricization. *Cultural Anthropology*, *11*(3), 377–404. https://doi.org/10.1525/can.1996.11.3.02a00050

Malkki, L. H. (1997). News and Culture: Transitory Phenomena and the Fieldwork Tradition. In A. Gupta & J. Ferguson (Eds.), *Anthropological locations: Boundaries and grounds of a field science* (pp. 86–101). University of California Press.

Marlow, M., Christie, H., Skeen, S., Rabie, S., Louw, J. G., Swartz, L., Mofokeng, S., Makhetha, M., & Tomlinson, M. (2021). Alcohol use during pregnancy in rural Lesotho: "There is nothing else except alcohol". *Social Science & Medicine*, *291*, 114482. https://doi.org/10.1016/j.socscimed.2021.114482

Marmo, M. (2013). The Ethical Implications of the Researcher's Dominant Position in Cross-Cultural Refugee Research. In K. Block, E. Riggs, & N. Haslam (Eds.), *Values and Vulnerabilities: The Ethics of Research with Refugees and Asylum Seekers* (pp. 85–102). Australia Academic Press. https://www.academia.edu/19640302/The_Ethical_Implications_of_the_Researchers_Dominant_Position_in_Cross_Cultural_Refugee_Research

Marshall, C. (2022). The inter-agency standing committee (IASC) guidelines on mental health and psychosocial support (MHPSS) in emergency settings: A critique. *International Review of Psychiatry*, *34*(6), 604–612. https://doi.org/10.1080/09540261.2022.2147420

Mastrorillo, M., Scognamillo, A., Ginet, C., Pietrelli, R., d'Errico, M., & Ignaciuk, A. (2022). *Enhancing refugees' self-reliance in Uganda: The role of cash and food assistance*. FAO. https://doi.org/10.4060/cc1838en

Mattingly, C. (2013). Moral Selves and Moral Scenes: Narrative Experiments in Everyday Life. *Ethnos*, *78*(3), 301–327. https://doi.org/10.1080/00141844.2012.691523

Mattingly, C. (2014). *Moral laboratories: Family peril and the struggle for a good life*. University of California Press.

Mavelli, L. (2019). Resilience beyond neoliberalism? Mystique of complexity, financial crises, and the reproduction of neoliberal life. *Resilience*, *7*(3), 224–239. https://doi.org/10.1080/21693293.2019.1605661

McLean, K. E. (2021). 'Post-crisis masculinities' in Sierra Leone: Revisiting masculinity theory. *Gender, Place & Culture*, *28*(6), 786–805. https://doi.org/10.1080/0966369X.2020.1825214

Meinert, L. (2009). *Hopes in Friction: Schooling, Health and Everyday Life in Uganda*. IAP.

Meinert, L., & Whyte, S. R. (2017a). Social Sensations of Symptoms: Embodied Socialities of HIV and Trauma in Uganda. *Anthropology in Action*, *24*(1), 20–26. https://doi.org/10.3167/aia.2017.240104

Meinert, L., & Whyte, S. R. (2017b). “These Things Continue”: Violence as Contamination in Everyday Life After War in Northern Uganda: Violence as Contamination. *Ethos*, *45*(2), 271–286. https://doi.org/10.1111/etho.12161

Meinert, L., & Whyte, S. R. (2020). Legacies of Violence: The Communicability of Spirits and Trauma in Northern Uganda. In J. Seeberg, A. Roepstorff, & L. Meinert (Eds.), *Biosocial Worlds*. UCL Press. https://doi.org/10.14324/111.9781787358232

Meinert, L., & Whyte, S. R. (Eds.). (2023). *This Land Is Not For Sale: Trust and Transitions in Northern Uganda*. Berghahn Books. https://doi.org/10.3167/9781800736979

Menjívar, C. (2006). Liminal Legality: Salvadoran and Guatemalan Immigrants’ Lives in the United States. *American Journal of Sociology*, *111*(4), 999–1037. https://doi.org/10.1086/499509

Mert, D. G., Turgut, N. H., Kelleci, M., & Semiz, M. (2015). Perspectives on reasons of medication nonadherence in psychiatric patients. *Patient Preference and Adherence*, *9*, 87–93. https://doi.org/10.2147/PPA.S75013

Mhina, M. A. (2009). Coping with Mental Distress in Contemporary Dar es Salaam. In L. Haram, C. B. Yamba, & Nordiska Afrikainstitutet (Eds.), *Dealing with uncertainty in contemporary African lives* (pp. 141–158). Nordiska Afrikainstitutet.

Middleton, H., & Moncrieff, J. (2019). Critical psychiatry: A brief overview. *BJPsych Advances*, *25*(1), 47–54. https://doi.org/10.1192/bja.2018.38

Miller, K. E., Jordans, M. J. D., Tol, W. A., & Galappatti, A. (2021). A call for greater conceptual clarity in the field of mental health and psychosocial support in humanitarian settings. *Epidemiology and Psychiatric Sciences*, *30*, e5. https://doi.org/10.1017/S2045796020001110

Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine*, *70*(1), 7–16. https://doi.org/10.1016/j.socscimed.2009.09.029

Mills, C. (2014). *Decolonizing Global Mental Health*. Routledge/Taylor & Francis Group.

Mills, C. (2015). The Psychiatrization of Poverty: Rethinking the Mental Health–Poverty Nexus. *Social and Personality Psychology Compass*, *9*(5), 213–222. https://doi.org/10.1111/spc3.12168

Mills, C. (2016). Mental Health and the Mindset of Development. In J. Grugel & D. Hammett (Eds.), *The Palgrave Handbook of International Development* (pp. 535–553). Palgrave Macmillan UK. https://doi.org/10.1057/978-1-137-42724-3_30

Mills, C. (2017). Psychopharmaceuticals as 'Essential Medicines': Local Negotiations of Global Access to Psychotherapeutic Medicines in India. In J. Davies (Ed.), *The Sedated Society: The Causes and Harms of our Psychiatric Drug Epidemic* (pp. 227–248). Springer International Publishing. https://doi.org/10.1007/978-3-319-44911-1_9

Mills, C. (2018a). From 'Invisible Problem' to Global Priority: The Inclusion of Mental Health in the Sustainable Development Goals. *Development and Change*, *49*(3), 843–866. https://doi.org/10.1111/dech.12397

Mills, C. (2018b). From 'Invisible Problem' to Global Priority: The Inclusion of Mental Health in the Sustainable Development Goals: Mental Health and the Sustainable Development Goals. *Development and Change*, *49*(3), 843–866. https://doi.org/10.1111/dech.12397

Mills, C. (2022). Strategic universality in the making of global guidelines for mental health. *Transcultural Psychiatry*, 13634615211068604. https://doi.org/10.1177/13634615211068605

Mills, C., & Fernando, S. (2014). Globalising Mental Health or Pathologising the Global South? Mapping the Ethics, Theory and Practice of Global Mental Health. *Disability and the Global South*, *1*(2), 188–202.

Mills, C., & Hilberg, E. (2019). 'Built for expansion': The 'social life' of the WHO's mental health GAP Intervention Guide. *Sociology of Health & Illness*, *41*(S1), 162–175. https://doi.org/10.1111/1467-9566.12870

Miura, K., & Tabata, Y. (2022). *Environmental Resource Scarcity and Peaceful Co-existence between Refugees and Host Communities in Uganda* (SSRN Scholarly Paper No. 4111506). https://doi.org/10.2139/ssrn.4111506

Mogensen, H. O. (2002). The Resilience of Juok: Confronting Suffering in Eastern Uganda. *Africa*, *72*(3), 420–436. https://doi.org/10.3366/afr.2002.72.3.420

Moncrieff, J. (2017). Opium and the People: The Prescription Psychopharmaceutical Epidemic in Historical Context. In J. Davies (Ed.), *The Sedated Society: The Causes and Harms of our Psychiatric Drug Epidemic* (pp. 73–99). Springer International Publishing. https://doi.org/10.1007/978-3-319-44911-1_4

Montenegro, C. R., & Ortega, F. (2020). Thinking beyond implementation: Context and culture in global mental health. *BMJ Global Health*, *5*(12), e004539. https://doi.org/10.1136/bmjgh-2020-004539

Morrison, J. S., & De Waal, A. (2005). Can Sudan Escape Its Intractability? In C. A. Crocker, *Grasping the Nettle: Analyzing Cases of Intractable Conflict* (pp. 161–182). US Institute of Peace Press.

Mugisha, J., Hanlon, C., Knizek, B. L., Ssebunnya, J., Vancampfort, D., Kinyanda, E., & Kigozi, F. (2019). The experience of mental health service users in health system strengthening: Lessons from Uganda. *International Journal of Mental Health Systems*, *13*(1), 60. https://doi.org/10.1186/s13033-019-0316-5

Mugisha, J., Muyinda, H., Wandiembe, P., & Kinyanda, E. (2015). Prevalence and factors associated with Posttraumatic Stress Disorder seven years after the conflict in three districts in northern Uganda (The Wayo-Nero Study). *BMC Psychiatry*, *15*(1), 170. https://doi.org/10.1186/s12888-015-0551-5

Mugisha, J., Ssebunnya, J., & Kigozi, F. N. (2016). Towards understanding governance issues in integration of mental health into primary health care in Uganda. *International Journal of Mental Health Systems*, *10*(1), 25. https://doi.org/10.1186/s13033-016-0057-7

Murray, C. J. L., Lopez, A. D., Organization, W. H., Bank, W., & Health, H. S. of P. (1996). *The Global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020 : summary*. World Health Organization. https://apps.who.int/iris/handle/10665/41864

Mutamba, B. B., van Ginneken, N., Smith Paintain, L., Wandiembe, S., & Schellenberg, D. (2013). Roles and effectiveness of lay community health workers in the prevention of mental, neurological and substance use disorders in low and middle income countries: A systematic review. *BMC Health Services Research*, *13*(1), 412. https://doi.org/10.1186/1472-6963-13-412

Mutegeki, G. (2019, April 12). Uganda on track towards achieving universal mental health care. *New Vision*. https://www.newvision.co.ug/articledetails/1498411

Myers, N. A. L. (2016). Recovery stories: An anthropological exploration of moral agency in stories of mental health recovery. *Transcultural Psychiatry*, *53*(4), 427–444. https://doi.org/10.1177/1363461516663124

Myers, N., & Yarris, K. E. (2019). Extraordinary Conditions: Global Psychiatric Care and the Anthropology of Moral Experience. *Ethos*, *47*(1), 3–12. https://doi.org/10.1111/etho.12224

Mylan, S., Torre, C., Parker, M., & Allen, T. (2019). Mental health in conflict settings. *The Lancet*, *394*(10216), 2237. https://doi.org/10.1016/S0140-6736(19)32552-8

Nakimuli-Mpungu, E., Alderman, S., Kinyanda, E., Allden, K., Betancourt, T. S., Alderman, J. S., Pavia, A., Okello, J., Nakku, J., Adaku, A., & Musisi, S. (2013). Implementation and Scale-Up of Psycho-Trauma Centers in a Post-Conflict Area: A Case Study of a Private–Public Partnership in Northern Uganda. *PLOS Medicine*, *10*(4), e1001427. https://doi.org/10.1371/journal.pmed.1001427

Nibbe, A. A. (2010). *The Effects of a Narrative Humanitarian Aid and Action in the Northern Uganda Conflict.The Effects of a Narrative Humanitarian Aid and Action in the Northern Uganda Conflict.* [PhD Thesis]. Department of Anthropology, University of California Davis.

O'Byrne, R. (2015). *Deities, Demons and Outsiders: The cosmological dimensions of (in)security and (in)justice in Pajok, South Sudan* (No. 21; Justice and Security Research Programme (JSRP), p. 56). https://assets.publishing.service.gov.uk/media/57a0898740f0b652dd000280/JSRP-21-OByrne.pdf

O'Byrne, R. J. (2016). *Becoming Christian: Personhood and Moral Cosmology in Acholi South Sudan*. University College London (UCL).

O'Byrne, R. J. (2022a). Marriage and belonging among South Sudanese Acholi refugees in New Zealand. *Journal of Immigrant & Refugee Studies*, *20*(3), 444–458. https://doi.org/10.1080/15562948.2021.1933295

O'Byrne, R. J. (2022b). Resistant Resilience: Agency and Resilience Among Refugees Resisting Humanitarian Corruption in Uganda. *Civil Wars*, *0*(0), 1–29. https://doi.org/10.1080/13698249.2022.2092686

O'Byrne, R. J., & Ogeno, C. (2020). Pragmatic Mobilities and Uncertain Lives: Agency and the Everyday Mobility of South Sudanese Refugees in Uganda. *Journal of Refugee Studies*, *33*(4), 747–765. https://doi.org/10.1093/jrs/feaa085

O'Connor, D., Boyle, P., Ilcan, S., & Oliver, M. (2017). Living with insecurity: Food security, resilience, and the World Food Programme (WFP). *Global Social Policy*, *17*(1), 3–20. https://doi.org/10.1177/1468018116658776

Office of the Prime Minister (OPM). (2021). *CRRF Strategic Direction 2021-2025*. Office of the Prime Minister. https://data.unhcr.org/en/documents/details/93224

Office of the Prime Minister (OPM), & United Nations High Commissioner for Refugees (UNHCR). (2018). *UGA Factsheet Palabek Gap Analysis – June 2018*. https://data2.unhcr.org/en/documents/details/67089

Office of the Prime Minister (OPM), & United Nations High Commissioner for Refugees (UNHCR). (2023a). *Palabek—Performance Dashboard*.

Office of the Prime Minister (OPM), & United Nations High Commissioner for Refugees (UNHCR). (2023b). *Uganda—Population Statistics as of April 2023*. https://reporting.unhcr.org/document/4803

Ogeno, C., & O'Byrne, R. J. (2018, October 11). Refugees in northern Uganda now have 'democracy', but no authority |. *Africa at LSE*.

https://blogs.lse.ac.uk/africaatlse/2018/10/11/refugees-in-northern-uganda-now-have-democracy-but-no-authority/

OIOS. (2018). *Audit of the Operations in Uganda for the Office of the United Nations High Commissioner for Refugees* (Report 2018/097 17 October 2018).

Okiror, S. (2023, February 8). Uganda condemned for 'shameful' decision to close UN human rights office. *The Guardian*. https://www.theguardian.com/world/2023/feb/08/uganda-condemned-decision-close-un-human-rights-office-museveni

Oldani, M., Ecks, S., & Basu, S. (2014). Anthropological Engagements with Modern Psychotropy. *Culture, Medicine, and Psychiatry*, *38*(2), 174–181. https://doi.org/10.1007/s11013-014-9374-y

Oliver, M., & Boyle, P. (2019). In and beyond the camp: The rise of resilience in refugee governance. *Oñati Socio-Legal Series*, *10*(6), 1107–1132. https://doi.org/10.35295/osls.iisl/0000-0000-0000-1050

Oliver, M., & Ilcan, S. (2018). The Politics of Protection: The Right to Food in Protracted Refugee Situations. *Refugee Survey Quarterly*, *37*(4), 440–457. https://doi.org/10.1093/rsq/hdy013

Olupot-Olupot, P., Katawera, A., Cooper, C., Small, W., Anema, A., & Mills, E. (2008). Adherence to antiretroviral therapy among a conflict-affected population in Northeastern Uganda: A qualitative study. *AIDS*, *22*(14), 1882. https://doi.org/10.1097/QAD.0b013e3283112ba6

Olwedo, M. A., Mworozi, E., Bachou, H., & Orach, C. G. (2008). Factors associated with malnutrition among children in internally displaced person's camps, northern Uganda. *African Health Sciences*, *8*(4), 244–252.

O'Malley, P. (2010). Resilient subjects: Uncertainty, warfare and liberalism. *Economy and Society*, *39*(4), 488–509. https://doi.org/10.1080/03085147.2010.510681

Omata, N. (2020). 'Over-researched' and 'Under-researched' refugee groups: Exploring the phenomena, causes and consequences. *Journal of Human Rights Practice*, *12*(3), 681–695. https://doi.org/10.1093/jhuman/huaa049

Ong, A. (2003). *Buddha Is Hiding: Refugees, Citizenship, the New America*.

Ortner, S. B. (2005). Subjectivity and cultural critique. *Anthropological Theory*, *5*(1), 31–52. https://doi.org/10.1177/1463499605050867

Ortner, S. B. (2016). Dark anthropology and its others: Theory since the eighties. *HAU: Journal of Ethnographic Theory*, *6*(1), 47–73. https://doi.org/10.14318/hau6.1.004

Ortner, S. B. (2015). Practicing engaged anthropology. *Anthropology of This Century*. http://aotcpress.com/articles/practicing-engaged-anthropology/

Ostuzzi, G., Barbui, C., Hanlon, C., Chatterjee, S., Eaton, J., Jones, L., Silove, D., & Ventevogel, P. (2017). Mapping the evidence on pharmacological interventions for non-affective psychosis in humanitarian non-specialised settings: A UNHCR clinical guidance. *BMC Medicine*, *15*(1), 197. https://doi.org/10.1186/s12916-017-0960-z

Otake, Y., & Tamming, T. (2021). Sociality and temporality in local experiences of distress and healing: Ethnographic research in northern Rwanda. *Transcultural Psychiatry*, *58*(4), 546–560. https://doi.org/10.1177/1363461520949670

p'Bitek, O. (1953). *White teeth*. Heinemann Kenya.

p'Bitek, O. (1964). Acholi Love. *Transition*, *75/76*, 182–190. https://doi.org/10.2307/2935404

p'Bitek, O. (1971). *Religion of the Central Luo*. East African Literature Bureau.

p'Bitek, O. (1972). *Song of Lawino and Song of Ocol*. East African Publishing House.

p'Bitek, O. (1986). *Artist, the Ruler: Essays on Art, Culture, and Values, Including Extracts from Song of Soldier and White Teeth Make People Laugh on Earth*. East African Publishers.

p'Bitek, O., Girling, F. K., & Allen, T. (2019). *Lawino's people: The Acholi of Uganda*. Lit.

Paddon Rhoads, E., & Sutton, R. (2020). *The (Self) Protection of Civilians in South Sudan: Popular and Community Justice Practices*. https://doi.org/10.2139/ssrn.3666945

Padmanathan, P., & Rai, D. (2016). Access and rational use of psychotropic medications in low- and middle-income countries. *Epidemiology and Psychiatric Sciences*, *25*(1), 4–8. https://doi.org/10.1017/S2045796015000803

Parker, M., & Allen, T. (2011). Does mass drug administration for the integrated treatment of neglected tropical diseases really work? Assessing evidence for the control of schistosomiasis and soil-transmitted helminths in Uganda. *Health Research Policy and Systems*, *9*(1), 3. https://doi.org/10.1186/1478-4505-9-3

Parkinson, S. E., & Behrouzan, O. (2015). Negotiating health and life: Syrian refugees and the politics of access in Lebanon. *Social Science & Medicine*, *146*, 324–331. https://doi.org/10.1016/j.socscimed.2015.10.008

Patel, V., Boyce, N., Collins, P. Y., Saxena, S., & Horton, R. (2011). A renewed agenda for global mental health. *Lancet (London, England)*, *378*(9801), 1441–1442. https://doi.org/10.1016/S0140-6736(11)61385-8

Patel, V., & Farmer, P. E. (2020). The moral case for global mental health delivery. *The Lancet*, *395*(10218), 108–109. https://doi.org/10.1016/S0140-6736(19)33149-6

Patel, V., & Kleinman, A. (2003). Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organization*, *81*(8), 609–615.

Patel, V., Minas, I. H., Cohen, A., & Prince, M. (Eds.). (2014). *Global mental health: Principles and practice*. Oxford University Press.

Patel, V., & Saxena, S. (2019). Achieving universal health coverage for mental disorders. *BMJ*, *366*, l4516. https://doi.org/10.1136/bmj.l4516

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., … UnÜtzer, Jü. (2018a). The Lancet Commission on global mental health and sustainable development. *The Lancet*, *392*(10157), 1553–1598. https://doi.org/10.1016/S0140-6736(18)31612-X

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., … UnÜtzer, Jü. (2018b). The Lancet Commission on global mental health and sustainable development. *The Lancet*, *392*(10157), 1553–1598. https://doi.org/10.1016/S0140-6736(18)31612-X

Pathare, S., Brazinova, A., & Levav, I. (2018). Care gap: A comprehensive measure to quantify unmet needs in mental health. *Epidemiology and Psychiatric Sciences*, *27*(5), 463–467. https://doi.org/10.1017/S2045796018000100

Pathare, S., Burgess, R. A., & Collins, P. Y. (2021). World Mental Health Day: Prioritise social justice, not only access to care. *The Lancet*, *398*(10314), 1859–1860. https://doi.org/10.1016/S0140-6736(21)02232-7

Payne, L. (1998). Food shortages and gender relations in Ikafe settlement, Uganda. *Gender & Development*, *6*(1), 30–36. https://doi.org/10.1080/741922625

Pedersen, D., Kienzler, H., & Guzder, J. (2015). Searching for Best Practices: A Systematic Inquiry Into the Nature of Psychosocial Interventions Aimed at Reducing the Mental Health Burden in Conflict and Postconflict Settings. *SAGE Open*, *5*(4), 2158244015615164. https://doi.org/10.1177/2158244015615164

Pendle, N. R. (2017). *Laws, landscapes and prophecy:* London School of Economics and Political Science.

Pendle, N. R. (2020). Politics, prophets and armed mobilizations: Competition and continuity over registers of authority in South Sudan's conflicts. *Journal of Eastern African Studies*, *14*(1), 43–62. https://doi.org/10.1080/17531055.2019.1708545

Penne, T., & Goedemé, T. (2021). Can low-income households afford a healthy diet? Insufficient income as a driver of food insecurity in Europe. *Food Policy*, *99*, 101978. https://doi.org/10.1016/j.foodpol.2020.101978

Pérez-Sales, P., Férnandez-Liria, A., Baingana, F., & Ventevogel, P. (2011). Integrating mental health into existing systems of care during and after complex humanitarian emergencies: Rethinking the experience. *Intervention - International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, *9*(3), 345–357.

Perkins, J. M., Nyakato, V. N., Kakuhikire, B., Tsai, A. C., Subramanian, S. V., Bangsberg, D. R., & Christakis, N. A. (2018). Food insecurity, social networks and symptoms of depression among men and women in rural Uganda: A cross-sectional, population-based study. *Public Health Nutrition*, *21*(5), 838–848. https://doi.org/10.1017/S1368980017002154

Petryna, A., Lakoff, A., & Kleinman, A. (Eds.). (2006). *Global pharmaceuticals ethics, markets, practices*. Duke University Press.

Pfeiffer, A., & Elbert, T. (2011). PTSD, depression and anxiety among former abductees in Northern Uganda. *Conflict and Health*, *5*(1), 14. https://doi.org/10.1186/1752-1505-5-14

Pillen, A. (2000). *The Discourse on Trauma in Non-Western Cultural Contexts* (pp. 87–102). https://doi.org/10.1007/978-1-4615-4177-6_6

Porter, A. (2013). ‘What is Constructed can be Transformed’: Masculinities in Post-Conflict Societies in Africa. *International Peacekeeping*, *20*(4), 486–506. https://doi.org/10.1080/13533312.2013.846137

Porter, H. (2013). *After Rape: Justice and Social Harmony in Northern Uganda*. London School of Economics and Political Science.

Porter, H. (2016). *After Rape: Violence, Justice, and Social Harmony in Uganda*. Cambridge University Press. https://doi.org/10.1017/9781316841297

Porter, H. (2019). Moral Spaces and Sexual Transgression: Understanding Rape in War and Post Conflict. *Development and Change*, *50*(4), 1009–1032. https://doi.org/10.1111/dech.12499

Pourmotabbed, A., Moradi, S., Babaei, A., Ghavami, A., Mohammadi, H., Jalili, C., Symonds, M. E., & Miraghajani, M. (2020). Food insecurity and mental health: A systematic review and meta-analysis. *Public Health Nutrition*, *23*(10), 1778–1790. https://doi.org/10.1017/S136898001900435X

Pratt, L. A., Brody, D. J., & Gu, Q. (2017). Antidepressant Use Among Persons Aged 12 and Over:United States,2011-2014. *NCHS Data Brief*, *283*, 1–8.

Pringle, Y. (2019). *Psychiatry and Decolonisation in Uganda*. Palgrave Macmillan UK. https://doi.org/10.1057/978-1-137-60095-0

Pupavac, V. (2001). Therapeutic Governance: Psycho-social Intervention and Trauma Risk Management. *Disasters*, *25*(4), 358–372. https://doi.org/10.1111/1467-7717.00184

Pupavac, V. (2004). Psychosocial Interventions and the Demoralization of Humanitarianism. *Journal of Biosocial Science*, *36*(4), 491–504. https://doi.org/10.1017/S0021932004006613

Pupavac, V. (2005). Human security and the rise of global therapeutic governance: Analysis. *Conflict, Security & Development*, *5*(2), 161–181. https://doi.org/10.1080/14678800500170076

Raikhel, E. (2013). Janis H. Jenkins (Ed.), Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacology. *Transcultural Psychiatry*, *50*(4), 599–604. https://doi.org/10.1177/1363461513504858

Ramsay, G. (2017). *Impossible Refuge: The Control and Constraint of Refugee Futures* (1st ed.). Routledge. https://doi.org/10.4324/9781315207711

Ramsay, G. (2020). Time and the other in crisis: How anthropology makes its displaced object. *Anthropological Theory*, *20*(4), 385–413. https://doi.org/10.1177/1463499619840464

Ranjbar, N., Erb, M., Mohammad, O., & Moreno, F. A. (2020). Trauma-Informed Care and Cultural Humility in the Mental Health Care of People From Minoritized Communities. *FOCUS*, *18*(1), 8–15. https://doi.org/10.1176/appi.focus.20190027

Read, U. (2012). "I want the one that will heal me completely so it won't come back again": The limits of antipsychotic medication in rural Ghana. *Transcultural Psychiatry*, *49*(3–4), 438–460. https://doi.org/10.1177/1363461512447070

Refugee Law Project (RLP). (2007). *"Giving out their daughters for their survival": Refugee self-reliance, "vulnerability", and the paradox of early marriage* (Working Paper No. 20; p. 65). Makerere University. http://www.refugeelawproject.org/files/working_papers/RLP.WP20.pdf

Reuters. (2018, November 29). U.N. audit finds graft and misconduct in its Uganda refugee program. *Reuters*. https://www.reuters.com/article/us-uganda-refugees-idUSKCN1NY230

Reuters. (2021, February 2). Ugandan opposition say 3,000 of their supporters seized since November. *Reuters*. https://www.reuters.com/article/uk-uganda-election-idUSKBN2A222P

Rifkin, S. B. (2018). Alma Ata after 40 years: Primary Health Care and Health for All—from consensus to complexity. *BMJ Global Health*, *3*(Suppl 3), e001188. https://doi.org/10.1136/bmjgh-2018-001188

Rimke, H. (2016a). Introduction – Mental and Emotional Distress as a Social Justice Issue: Beyond Psychocentrism. *Studies in Social Justice*, *10*(1), Article 1. https://doi.org/10.26522/ssj.v10i1.1407

Rimke, H. (2016b). Introduction – Mental and Emotional Distress as a Social Justice Issue: Beyond Psychocentrism. *Studies in Social Justice*, *10*(1), 4–17. https://doi.org/10.26522/ssj.v10i1.1407

Rimke, H. (2020). Self-Help, Therapeutic Industries, and Neoliberalism. In D. Nehring, O. J. Madsen, E. Cabanas, C. Mills, & D. Kerrigan (Eds.), *The Routledge International Handbook of Global Therapeutic Cultures* (1st ed., pp. 37–50). Routledge. https://www.routledge.com/The-Routledge-International-Handbook-of-Global-Therapeutic-Cultures/Nehring-Madsen-Cabanas-Mills-Kerrigan/p/book/9780367509682

Rivera-Segarra, E., Mascayano, F., Alnasser, L., van der Ven, E., Martínez-Alés, G., Durand-Arias, S., Moro, M. F., Karam, E., Hernández-Torres, R., Alarcón, S., Ramos-Pibernus, A., Alvarado, R., & Susser, E. (2022). Global mental health research and practice: A decolonial approach. *The Lancet Psychiatry*, *9*(7), 595–600. https://doi.org/10.1016/S2215-0366(22)00043-8

Robbins, J. (2013). Beyond the suffering subject: Toward an anthropology of the good. *Journal of the Royal Anthropological Institute*, *19*(3), 447–462. https://doi.org/10.1111/1467-9655.12044

Robbins, J. (2016). What is the matter with transcendence? On the place of religion in the new anthropology of ethics★. *Journal of the Royal Anthropological Institute*, *22*(4), 767–781. https://doi.org/10.1111/1467-9655.12494_1

Roberts, B., Ocaka, K. F., Browne, J., Oyok, T., & Sondorp, E. (2008). Factors associated with post-traumatic stress disorder and depression amongst internally displaced persons in northern Uganda. *BMC Psychiatry*, *8*(1), 38. https://doi.org/10.1186/1471-244X-8-38

Roberts, T., Esponda, G. M., Torre, C., Pillai, P., Cohen, A., & Burgess, R. A. (2022). Reconceptualising the treatment gap for common mental disorders: A fork in the road for global mental health? *The British Journal of Psychiatry*, 1–5. https://doi.org/10.1192/bjp.2021.221

Robinson, J., Chiumento, A., Kasujja, R., Rutayisire, T., & White, R. (2022). The 'good life', personal appearance, and mental health of Congolese refugees in Rwanda and Uganda. *Social Science & Medicine*, *293*, 114641. https://doi.org/10.1016/j.socscimed.2021.114641

Robinson, R. G., McHugh, P. R., & Folstein, M. F. (1975). Measurement of appetite disturbances in psychiatric disorders. *Journal of Psychiatric Research*, *12*(1), 59–68. https://doi.org/10.1016/0022-3956(75)90021-7

Rolandsen, Ø. H., Glomnes, H. M., Manoeli, S., & Nicolaisen, F. (2015). A year of South Sudan's third civil war. *International Area Studies Review*, *18*(1), 87–104. https://doi.org/10.1177/2233865915573797

Rolandsen, Ø. H., & Kindersley, N. (2017). South Sudan: A Political Economy Analysis. Landanalyserapport. *VIII, 42 p.* https://nupi.brage.unit.no/nupi-xmlui/handle/11250/2460927

Rose, D., & Rose, N. (2023). Is 'another' psychiatry possible? *Psychological Medicine*, *53*(1), 46–54. https://doi.org/10.1017/S003329172200383X

Rose, N. (1998). *Inventing Our Selves: Psychology, Power, and Personhood*. Cambridge University Press.

Rosenbloom, M. (2002). Chlorpromazine and the Psychopharmacologic Revolution. *JAMA*, *287*(14), 1860–1861. https://doi.org/10.1001/jama.287.14.1860-JMS0410-6-1

Sackett, B. (2023). A uniform front?: Power and front-line worker variation in Kakuma refugee camp, Kenya. *Ethnography*, *24*(1), 106–131. https://doi.org/10.1177/14661381221104288

Sakti, V. K., & Amrith, M. (2022). Introduction: Living in the 'Here and Now': Extended Temporalities of Forced Migration. *Journal of Intercultural Studies*, *43*(4), 457–463. https://doi.org/10.1080/07256868.2022.2088084

Sampson, H., & Thomas, M. (2003). Risk and Responsibility. *Qualitative Research*, *3*(2), 165–189. https://doi.org/10.1177/14687941030032002

Sampson, R. C., Gifford, S. M., & Taylor, S. (2016). The myth of transit: The making of a life by asylum seekers and refugees in Indonesia. *Journal of Ethnic and Migration Studies*, *42*(7), 1135–1152. https://doi.org/10.1080/1369183X.2015.1130611

Sarpatwari, A., Sinha, M. S., & Kesselheim, A. S. (2017). The Opioid Epidemic: Fixing a Broken Pharmaceutical Market. *Harvard Law & Policy Review*, *11*(2), 463–484.

Savic, M., Chur-Hansen, A., Mahmood, M. A., & Moore, V. M. (2016). 'We don't have to go and see a special person to solve this problem': Trauma, mental health beliefs and processes for addressing 'mental health issues' among Sudanese refugees in Australia. *International Journal of Social Psychiatry*, *62*(1), 76–83. https://doi.org/10.1177/0020764015595664

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity, and inefficiency. *The Lancet*, *370*(9590), 878–889. https://doi.org/10.1016/S0140-6736(07)61239-2

Schafer, A. (2010). Spirituality and mental health in humanitarian contexts: An exploration based on World Vision's Haiti earthquake response. *Intervention - International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, *8*(2), 121–130.

Scheper-Hughes, N. (1994). An essay: AIDS and the social body. *Social Science & Medicine*, *39*(7), 991–1003. https://doi.org/10.1016/0277-9536(94)90210-0

Schiltz, J., & Büscher, K. (2018). Brokering research with war-affected people: The tense relationship between opportunities and ethics. *Ethnography*, *19*(1), 124–146. https://doi.org/10.1177/1466138116664542

Schiltz, J., Derluyn, I., Vanderplasschen, W., & Vindevogel, S. (2019). Resilient and Self-reliant Life: South Sudanese Refugees Imagining Futures in the Adjumani Refugee Setting, Uganda. *Children & Society*, *33*(1), 39–52. https://doi.org/10.1111/chso.12304

Schiltz, J., Vindevogel, S., Derluyn, I., & Vanderplasschen, W. (2019). Uncertainty in situations of forced displacement: A critical interpretative synthesis of refugee literature. *Population, Space and Place*, *25*(3), e2194. https://doi.org/10.1002/psp.2194

Schlosser, A. V., & Hoffer, L. D. (2012). The Psychotropic Self/Imaginary: Subjectivity and Psychopharmaceutical Use Among Heroin Users with Co-Occurring Mental Illness. *Culture, Medicine, and Psychiatry*, *36*(1), 26–50. https://doi.org/10.1007/s11013-011-9244-9

Schomerus, M. (2007). *The Lord's Resistance Army in Sudan: A History and Overview*. Small Arms Survey, Graduate Institute of International Studies.

Schomerus, M. (2008, November). *Perilous border: Sudanese communities affected by conflict on the Sudan-Uganda border* [Monograph]. Conciliation Resources. http://www.c-r.org/index.php

Schram, S. (2000). In the Clinic: The Medicalization of Welfare. *Social Text*, *18*(1), 81–107.

Schramm, S., Kaducu, F. O., Smedemark, S. A., Ovuga, E., & Sodemann, M. (2016). Gender and age disparities in adult undernutrition in northern Uganda: High-risk groups not targeted by food aid programmes. *Tropical Medicine & International Health*, *21*(6), 807–817. https://doi.org/10.1111/tmi.12708

Schulz, P. (2018). Displacement from gendered personhood: Sexual violence and masculinities in northern Uganda. *International Affairs*, *94*(5), 1101–1119. https://doi.org/10.1093/ia/iiy146

Semahegn, A., Torpey, K., Manu, A., Assefa, N., Tesfaye, G., & Ankomah, A. (2020). Psychotropic medication non-adherence and its associated factors among patients with major psychiatric disorders: A systematic review and meta-analysis. *Systematic Reviews*, *9*(1), 17. https://doi.org/10.1186/s13643-020-1274-3

Sengupta, A., & Calo, M. (2016). Shifting gender roles: An analysis of violence against women in post-conflict Uganda. *Development in Practice*, *26*(3), 285–297. https://doi.org/10.1080/09614524.2016.1149151

Shorter, E. (2014). The 25th anniversary of the launch of Prozac gives pause for thought: Where did we go wrong? *The British Journal of Psychiatry*, *204*(5), 331–332. https://doi.org/10.1192/bjp.bp.113.129916

Silberschmidt, M. (2001). Disempowerment of Men in Rural and Urban East Africa: Implications for Male Identity and Sexual Behavior. *World Development*, *29*(4), 657–671. https://doi.org/10.1016/S0305-750X(00)00122-4

Silberschmidt, M. (2004). Masculinities, Sexuality and Socio-Economic Change in Rural and Urban East Africa. In S. Arnfred (Ed.), *Re-Thinking Sexualities in Africa* (pp. 233–248).

Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: An overview of mental health challenges. *World Psychiatry*, *16*(2), 130–139. https://doi.org/10.1002/wps.20438

Simpson, A. (2007). On Ethnographic Refusal: Indigeneity, 'Voice' and Colonial Citizenship. *Junctures*, *9*, 67–80.

Skran, C., & Easton-Calabria, E. (2020). Old Concepts Making New History: Refugee Self-reliance, Livelihoods and the 'Refugee Entrepreneur'. *Journal of Refugee Studies*, *33*(1), 1–21. https://doi.org/10.1093/jrs/fez061

Slaughter, A., Tiwari, A. D., Wake, C., Carpi, E., Easton-Calabria, E., Field, J., Leeson, K., Krause, U., Barbelet, V., & Mookherjee, Y. (2017). *Refugee self-reliance: Moving beyond the marketplace* (No. 7; RSC Research in Brief, p. 6). Refugees Studies Centre. https://www.rsc.ox.ac.uk/publications/refugee-self-reliance-moving-beyond-the-marketplace

Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples*. Zed Books ; University of Otago Press ; Distributed in the USA exclusively by St. Martin's Press.

Sökefeld, M. (1999). Debating Self, Identity, and Culture in Anthropology. *Current Anthropology*, *40*(4), 417–448. https://doi.org/10.1086/200042

Sonne, C., Carlsson, J., Bech, P., & Mortensen, E. L. (2017). Pharmacological treatment of refugees with trauma-related disorders: What do we know today? *Transcultural Psychiatry*, *54*(2), 260–280. https://doi.org/10.1177/1363461516682180

Ssebunnya, J., Kangere, S., Mugisha, J., Docrat, S., Chisholm, D., Lund, C., & Kigozi, F. (2018). Potential strategies for sustainably financing mental health care in Uganda. *International Journal of Mental Health Systems*, *12*(1), 74. https://doi.org/10.1186/s13033-018-0252-9

Stein, D., Bergemann, R., Lanthorn, H., Kimani, E., Nshakira-Rukundo, E., & Li, Y. (2022). Cash, COVID-19 and aid cuts: A mixed-method impact evaluation among South Sudanese refugees registered in Kiryandongo settlement, Uganda. *BMJ Global Health*, *7*(5), e007747. https://doi.org/10.1136/bmjgh-2021-007747

Stel, N. (2020). *Hybrid Political Order and the Politics of Uncertainty: Refugee Governance in Lebanon*. https://doi.org/10.4324/9780429434716

Stevenson, L. (2020). What There is to Fear: Scenes of Worldmaking and Unmaking in the Aftermaths of Violence. *Ethnos*, *85*(4), 647–664. https://doi.org/10.1080/00141844.2019.1636843

Stolorow, R. D. (2003). Trauma and temporality. *Psychoanalytic Psychology*, *20*(1), 158–161. https://doi.org/10.1037/0736-9735.20.1.158

Storer, E. (2020). *Lugbara Religion Revisited: A Study of Social Repair In West Nile, North-West Uganda*. London School of Economics and Political Science.

Storer, E., & Torre, C. (2023). 'All in good faith?' An ethno-historical analysis of local faith actors' involvement in the delivery of mental health interventions in northern Uganda. *Transcultural Psychiatry*, 13634615221149348. https://doi.org/10.1177/13634615221149349

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine (1982)*, *48*(10), 1449–1462. https://doi.org/10.1016/s0277-9536(98)00450-x

Summerfield, D. (2000a). Childhood, War, Refugeedom and 'Trauma': Three Core Questions for Mental Health Professionals. *Transcultural Psychiatry*, *37*(3), 417–433. https://doi.org/10.1177/136346150003700308

Summerfield, D. (2000b). War and mental health: A brief overview. *BMJ*, *321*(7255), 232–235. https://doi.org/10.1136/bmj.321.7255.232

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ*, *322*(7278), 95–98. https://doi.org/10.1136/bmj.322.7278.95

Summerfield, D. (2003). War, Exile, Moral Knowledge and the Limits of Psychiatric Understanding: A Clinical Case Study of a Bosnian Refugee in London. *International Journal of Social Psychiatry*, *49*(4), 264–268. https://doi.org/10.1177/0020764003494004

Summerfield, D. (2004). Cross-cultural perspectives on the medicalization of human suffering. In *Posttraumatic stress disorder: Issues and controversies* (pp. 233–245). John Wiley & Sons Ltd. https://doi.org/10.1002/9780470713570.ch12

Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *BMJ*, *336*(7651), 992–994. https://doi.org/10.1136/bmj.39513.441030.AD

Summerfield, D. (2013). 'Global mental health' is an oxymoron and medical imperialism. *BMJ (Clinical Research Ed.)*, *346*, f3509. https://doi.org/10.1136/bmj.f3509

Tankink, M. T. A., Belay, H. T., Mukasa, M. B., Niewe Weme, D., Burman, M., & Ventevogel, P. (2023). *Culture, Context and Mental Health and Psychosocial Well-Being of Refugees and Internally Displaced Persons from South Sudan* (p. 132). UNHCR.

https://reliefweb.int/report/south-sudan/culture-context-and-mental-health-and-psychosocial-well-being-refugees-and-internally-displaced-persons-south-sudan

Tapscott, R. (2018). Policing men: Militarised masculinity, youth livelihoods, and security in conflict-affected northern Uganda. *Disasters*, *42*, S119–S139. https://doi.org/10.1111/disa.12274

Tapscott, R. (2021). *Arbitrary states: Social control and modern authoritarianism in Museveni's Uganda* (First edition). Oxford University Press.

Tarannum, S., Elshazly, M., Harlass, S., & Ventevogel, P. (2019). Integrating mental health into primary health care in Rohingya refugee settings in Bangladesh: Experiences of UNHCR. *Intervention*, *17*(2), 130. https://doi.org/10.4103/INTV.INTV_34_19

Tazzioli, M. (2018). Containment through mobility: Migrants' spatial disobediences and the reshaping of control through the hotspot system. *Journal of Ethnic and Migration Studies*, *44*(16), 2764–2779. https://doi.org/10.1080/1369183X.2017.1401514

Tazzioli, M. (2019). Refugees' Debit Cards, Subjectivities, and Data Circuits: Financial-Humanitarianism in the Greek Migration Laboratory. *International Political Sociology*, *13*(4), 392–408. https://doi.org/10.1093/ips/olz014

Tazzioli, M. (2020a). Disjointed knowledges, obfuscated visibility. Border controls at the French-Italian Alpine border. *Political Geography*, *79*, 102155. https://doi.org/10.1016/j.polgeo.2020.102155

Tazzioli, M. (2020b). What is Left of Migrants' Spaces?: Transversal Alliances and the Temporality of Solidarity. *Political Anthropological Research on International Social Sciences*, *1*(1), 137–161. https://doi.org/10.1163/25903276-bja10001

Tazzioli, M. (2021). A "Passport to Freedom"? COVID-19 and the Re-bordering of the World. *European Journal of Risk Regulation*, *12*(2), 355–361. https://doi.org/10.1017/err.2021.31

Teferra, S., Hanlon, C., Beyero, T., Jacobsson, L., & Shibre, T. (2013). Perspectives on reasons for non-adherence to medication in persons with schizophrenia in Ethiopia: A qualitative study of patients, caregivers and health workers. *BMC Psychiatry*, *13*(1), 168. https://doi.org/10.1186/1471-244X-13-168

The Observer Uganda. (2020, September 15). Death toll in Rhino refugee camp clashes rises to 10. *The Observer - Uganda*. https://observer.ug/news/headlines/66565-death-toll-in-rhino-refugee-camp-clashes-rises-to-10

Thornicroft, G., Chatterji, S., Evans-Lacko, S., Gruber, M., Sampson, N., Aguilar-Gaxiola, S., Al-Hamzawi, A., Alonso, J., Andrade, L., Borges, G., Bruffaerts, R., Bunting, B., Almeida, J. M. C. de, Florescu, S., Girolamo, G. de, Gureje, O., Haro, J. M., He, Y., Hinkov, H., … Kessler,

R. C. (2017). Undertreatment of people with major depressive disorder in 21 countries. *The British Journal of Psychiatry*, *210*(2), 119–124. https://doi.org/10.1192/bjp.bp.116.188078

Thornicroft, G., & Semrau, M. (2019). Health system strengthening for mental health in low- and middle-income countries: Introduction to the Emerald programme. *BJPsych Open*, *5*(5), e66. https://doi.org/10.1192/bjo.2019.9

Titeca, K. (2022a). Who depends on whom? Uganda's refugee 'success story', corruption and the international community. *Third World Quarterly*, *43*(1), 55–73. https://doi.org/10.1080/01436597.2021.1989301

Titeca, K. (2022b, December 7). Who paid the price for Uganda's refugee fraud scandal (and who didn't)? *The New Humanitarian*. https://www.thenewhumanitarian.org/investigation/2022/12/07/Uganda-UNHCR-refugee-fraud-corruption

Titeca, K. (2023, April 21). Fresh fraud concerns hit Uganda's refugee programme. *The New Humanitarian*. https://www.thenewhumanitarian.org/news/2023/04/21/uganda-refugee-programme-fraud-concerns

Tjørnhøj-Thomsen, T., & Whyte, S. R. (2008). Fieldwork and Participant Observation. In S. Vallgårda & L. Koch (Eds.), *Research Methods in Public Health* (1st ed., pp. 91–120). Munksgaard Danmark.

Toffolutti, V., Stuckler, D., & McKee, M. (2020). Is the COVID-19 pandemic turning into a European food crisis? *The European Journal of Public Health*, *30*(4), 626–627. https://doi.org/10.1093/eurpub/ckaa101

Tol, W. A., Ager, A., Bizouerne, C., Bryant, R., El Chammay, R., Colebunders, R., García-Moreno, C., Hamdani, S. U., James, L. E., Jansen, S. C. J., Leku, M. R., Likindikoki, S., Panter-Brick, C., Pluess, M., Robinson, C., Ruttenberg, L., Savage, K., Welton-Mitchell, C., Hall, B. J., … van Ommeren, M. (2020). Improving mental health and psychosocial wellbeing in humanitarian settings: Reflections on research funded through R2HC. *Conflict and Health*, *14*(1), 71. https://doi.org/10.1186/s13031-020-00317-6

Tol, W. A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., Golaz, A., & van Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: Linking practice and research. *The Lancet*, *378*(9802), 1581–1591. https://doi.org/10.1016/S0140-6736(11)61094-5

Tol, W. A., Leku, M. R., Lakin, D. P., Carswell, K., Augustinavicius, J., Adaku, A., Au, T. M., Brown, F. L., Bryant, R. A., Garcia-Moreno, C., Musci, R. J., Ventevogel, P., White, R. G., & van Ommeren, M. (2020). Guided self-help to reduce psychological distress in South

Sudanese female refugees in Uganda: A cluster randomised trial. *The Lancet Global Health*, *8*(2), e254–e263. https://doi.org/10.1016/S2214-109X(19)30504-2

Tol, W. A., Purgato, M., Bass, J. K., Galappatti, A., & Eaton, W. (2015). Mental health and psychosocial support in humanitarian settings: A public mental health perspective. *Epidemiology and Psychiatric Sciences*, *24*(6), 484–494. Scopus. https://doi.org/10.1017/S2045796015000827

Torre, C. (2019). *Psychosocial Support (PSS) in War-affected Countries: A literature review* (Working Paper No. 3; Politics of Return). London School of Economics and Political Science. https://eprints.lse.ac.uk/100199/1/Torre_PSSin_War_affectedCountries.pdf

Torre, C. (2020). Self-help or silenced voices? An ethnographically informed warning. *The Lancet Global Health*, *8*(5), e646. https://doi.org/10.1016/S2214-109X(20)30106-6

Torre, C. (2021). Therapy in Uganda: A failed MHPSS approach in the face of structural issues. *Forced Migration Review*, *66*, 43–45.

Torre, C. (2023). “Think Positive, Save a life”? Resilience and Mental Health Interventions as Political Abandonment in a Refugee Settlement in Northern Uganda. *Civil Wars*. https://www.tandfonline.com/doi/abs/10.1080/13698249.2023.2209485

Torre, C., Mylan, S., Parker, M., & Allen, T. (2019). Is promoting war trauma such a good idea? *Anthropology Today*, *35*(6), 3–6. https://doi.org/10.1111/1467-8322.12538

Tran, A. L., Đan Tâm, T., Thúc Dũng, H., & Cúc Trâm, N. (2020). Drug adherence, medical pluralism, and psychopharmaceutical selfhood in postreform Vietnam. *Transcultural Psychiatry*, *57*(1), 81–93. https://doi.org/10.1177/1363461519893136

Trigger, D., Forsey, M., & Meurk, C. (2012). Revelatory moments in fieldwork. *Qualitative Research*, *12*(5), 513–527. https://doi.org/10.1177/1468794112446049

Trudell, J. P., Burnet, M. L., Ziegler, B. R., & Luginaah, I. (2021). The impact of food insecurity on mental health in Africa: A systematic review. *Social Science & Medicine*, *278*, 113953. https://doi.org/10.1016/j.socscimed.2021.113953

Tseris, E. (2017). *Biomedicine, neoliberalism and the pharmaceuticalisation of society*. Routledge Handbooks Online. https://doi.org/10.4324/9781315399584.ch19

Tuhiwai-Smith, L. (2012). *Decolonizing methodologies: Research and indigenous peoples* (Second edition). Zed Books.

Turner, L. (2015). On encampment and gendered vulnerabilities. *Oxford Monitor of Forced Migration*, *5*(2), 21–25.

Turner, L. (2019). Syrian refugee men as objects of humanitarian care. *International Feminist Journal of Politics*, *21*(4), 595–616. https://doi.org/10.1080/14616742.2019.1641127

Turner, V. W. (1967). *The Forest of Symbols: Aspects of Ndembu Ritual*. Cornell University Press.

Twecan, D., Wang, W., Xu, J., & Mohmmed, A. (2022). Climate change vulnerability, adaptation measures, and risk perceptions at households level in Acholi sub-region, Northern Uganda. *Land Use Policy*, *115*, 106011. https://doi.org/10.1016/j.landusepol.2022.106011

UN General Assembly. (2015). *Transforming our world: The 2030 Agenda for Sustainable Development*. https://www.refworld.org/docid/57b6e3e44.html

United Nations High Commissioner for Refugees (UNHCR). (2005). *Handbook for Self-Reliance*. UNHCR. https://www.unhcr.org/44bf7b012.pdf

United Nations High Commissioner for Refugees (UNHCR). (2017a). *Comprehensive Refugee Response Framework - Uganda: The Way Forward*. https://data.unhcr.org/en/documents/details/63266

United Nations High Commissioner for Refugees (UNHCR). (2017b). *Resilience and self-reliance from a protection and solutions perspective*. https://www.unhcr.org/excom/standcom/58ca4f827/resilience-self-reliance-protection-solutions-perspective.html

United Nations High Commissioner for Refugees (UNHCR). (2018). *Comprehensive Refugee Response Framework: The Uganda Model* [Comprehensive Response - Case Study]. UNHCR. https://globalcompactrefugees.org/sites/default/files/2019-12/Case%20study-%20comprehensive%20refugee%20response%20model%20in%20Uganda%282018%29.pdf

United Nations High Commissioner for Refugees (UNHCR). (2019a). *Mental Health and Psychosocial Support in the Uganda Refugee Response* [Briefing]. UNHCR.

United Nations High Commissioner for Refugees (UNHCR). (2019b). *Uganda Country Refugee Response Plan: January 2019—December 2020*. UNHCR. https://reporting.unhcr.org/sites/default/files/Uganda%20Country%20RRP%202019-20%20%28January%202019%29.pdf

United Nations High Commissioner for Refugees (UNHCR). (2021). *Most Underfunded Situations in 2021*. UNHCR. https://reporting.unhcr.org/sites/default/files/Underfunding-Report-2021.pdf

United Nations High Commissioner for Refugees (UNHCR). (2022a). *Global Trends Report 2021*. https://www.unhcr.org/publications/brochures/62a9d1494/global-trends-report-2021.html

United Nations High Commissioner for Refugees (UNHCR). (2022b). *Mid-Year Trends 2022* (p. 28). UNHCR. https://www.unhcr.org/statistics/unhcrstats/635a578f4/mid-year-trends-2022.html

United Nations High Commissioner for Refugees (UNHCR). (2022c). *South Sudan: Regional Refugee Response Plan 2022*. https://data.unhcr.org/en/documents/details/91426

United Nations High Commissioner for Refugees (UNHCR). (2022d). *Uganda—Analysis of suicide incidents, March 2022*. https://reliefweb.int/report/uganda/uganda-analysis-suicide-incidents-march-2022

United Nations High Commissioner for Refugees (UNHCR). (2020, 24 January). *Suicides on the rise among South Sudanese refugees in Uganda*. UNHCR. https://www.unhcr.org/news/stories/2020/1/5e2afb5b4/suicides-rise-among-south-sudanese-refugees-uganda.html

United Nations High Commissioner for Refugees (UNHCR). (2022e). *Uganda Refugee Response: Suicide Dashboard Quarter 4 2022*. UNHCR Operational Data Portal (ODP). https://data.unhcr.org/en/documents/details/98223

United Nations High Commissioner for Refugees (UNHCR). (2023). *Global Appeal 2023*. https://reporting.unhcr.org/globalappeal

United Nations High Commissioner for Refugees (UNHCR). (n.d.a). *Country—Uganda*. Uganda Comprehensive Refugee Response Portal. https://data.unhcr.org/en/country/uga

United Nations High Commissioner for Refugees (UNHCR). (n.d.b). *The Sustainable Development Goals and the Global Compact on Refugees*. https://www.unhcr.org/events/conferences/5efcb5004/sustainable-development-goals-global-compact-refugees.html

United Nations Human Rights Council. (2017). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development).

United Nations Office for the Coordination of Humanitarian Affairs (OCHA). (2022). *South Sudan Humanitarian Snapshot August 2022*. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/south_sudan_humanitarian_snapshot_august.pdf

United Nations, & World Bank. (2017). *ReHoPe—Refugee and Host Population Empowerment: Strategic Framework, Uganda.* https://reliefweb.int/sites/reliefweb.int/files/resources/64166_0.pdf

Vallières, F., Mannan, H., Kodate, N., & Larkan, F. (2022). *Systems Thinking for Global Health: How can systems-thinking contribute to solving key challenges in Global Health?* Oxford University Press.

van der Geest, S. (1984). Anthropology and Pharmaceuticals in Developing Countries. *Medical Anthropology Quarterly*, *15*(3), 59–62.

van der Geest, S. (2006). New Release: Anthropology and the Pharmaceutical Nexus. *Anthropological Quarterly*, *79*(2), 303–314.

van der Geest, S., & Whyte, S. R. (1989). The Charm of Medicines: Metaphors and Metonyms. *Medical Anthropology Quarterly*, *3*(4), 345–367. https://doi.org/10.1525/maq.1989.3.4.02a00030

van der Geest, S., Whyte, S. R., & Hardon, A. (1996). The Anthropology of Pharmaceuticals: A Biographical Approach. *Annual Review of Anthropology*, *25*(1), 153–178. https://doi.org/10.1146/annurev.anthro.25.1.153

Van Ommeren, M. van, Barbui, C., Jong, K. de, Dua, T., Jones, L., Perez-Sales, P., Schilperoord, M., Ventevogel, P., Yasamy, M. T., & Saxena, S. (2011). If You Could Only Choose Five Psychotropic Medicines: Updating the Interagency Emergency Health Kit. *PLOS Medicine*, *8*(5), e1001030. https://doi.org/10.1371/journal.pmed.1001030

Vancluysen, S., & Ingelaere, B. (2020). Conflict resolution as cultural brokerage: How refugee leaders mediate disputes in Uganda’s refugee settlements. *Journal of Refugee Studies*, *33*(2), 300–315. https://doi.org/10.1093/jrs/feaa037

Vaughan, M. (2016). Changing the Subject? Psychological Counseling in Eastern Africa. *Public Culture*, *28*(3), 499–517. https://doi.org/10.1215/08992363-3511514

Ventevogel, P. (2014). Integration of mental health into primary healthcare in low-income countries: Avoiding medicalization. *International Review of Psychiatry*, *26*(6), 669–679. https://doi.org/10.3109/09540261.2014.966067

Ventevogel, P. (2018). Interventions for Mental Health and Psychosocial Support in Complex Humanitarian Emergencies: Moving Towards Consensus in Policy and Action? In N. Morina & A. Nickerson (Eds.), *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice* (pp. 155–180). Springer International Publishing. https://doi.org/10.1007/978-3-319-97046-2_8

Ventevogel, P., Jordans, M., Reis, R., & de Jong, J. (2013). Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. *Conflict and Health*, *7*, 3. https://doi.org/10.1186/1752-1505-7-3

Ventevogel, P., Ommeren, M. van, Schilperoord, M., & Saxena, S. (2015). Improving mental health care in humanitarian emergencies. *Bulletin of the World Health Organization*, *93*, 666–666. https://doi.org/10.2471/BLT.15.156919

Ventevogel, P., Put, W. van de, Faiz, H., Mierlo, B. van, Siddiqi, M., & Komproe, I. H. (2012). Improving Access to Mental Health Care and Psychosocial Support within a Fragile Context: A Case Study from Afghanistan. *PLOS Medicine*, *9*(5), e1001225. https://doi.org/10.1371/journal.pmed.1001225

Verdirame, G., & Harrell-Bond, B. (2005). *Rights in Exile: Janus-Faced Humanitarianism*. BERGHAHN BOOKS INC.

Verginer, L., & Juen, B. H. (2019). Spiritual Explanatory Models of Mental Illness in West Nile, Uganda. *Journal of Cross-Cultural Psychology*, *50*(2), 233–253. https://doi.org/10.1177/0022022118813652

Victor, L. E. (2018). *Ghostly Vengeance: Spiritual Pollution, Time, and Other Uncertainties in Acholi* [PhD Thesis]. Department of Anthropology, University of Toronto.

Victor, L., & Porter, H. (2017). Dirty things: Spiritual pollution and life after the Lord's Resistance Army. *Journal of Eastern African Studies*, *11*(4), 590–608. https://doi.org/10.1080/17531055.2017.1373441

Vorhölter, J. (2019). Struggling to Be a "Happy Self"? Psychotherapy and the Medicalization of Unhappiness in Uganda. *Current Anthropology*, *60*(2), 194–223. https://doi.org/10.1086/702337

Vorhölter, J. (2021). Family Trouble: Changing (Dis)Orders and Psychotherapeutic Interventions in Uganda. *Ethos*, *49*(4), 379–400. https://doi.org/10.1111/etho.12309

Wagenaar, B. H., Hammett, W. H., Jackson, C., Atkins, D. L., Belus, J. M., & Kemp, C. G. (2020). Implementation outcomes and strategies for depression interventions in low- and middle-income countries: A systematic review. *Global Mental Health*, *7*, e7. https://doi.org/10.1017/gmh.2020.1

Wainman, N., Whyte, S. R., & Meinert, L. (2022). Textures of precarity: Repurposing in a Ugandan refugee settlement. *Anthropology Today*, *38*(4), 19–22. https://doi.org/10.1111/1467-8322.12744

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science & Medicine*, *52*(11), 1709–1718. https://doi.org/10.1016/S0277-9536(00)00284-7

Watters, C. (2017). Three Challenges to a Life Course Approach in Global Mental Health: Epistemic Violence, Temporality and Forced Migration. In R. G. White, S. Jain, D. M. R. Orr, & U. M. Read (Eds.), *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health* (pp. 237–256). Palgrave Macmillan UK. https://doi.org/10.1057/978-1-137-39510-8_12

Weiss, T. G., Wilkinson, R., & Miller, S. D. (2017). *UNHCR as a Surrogate State: Protracted Refugee Situations*. Routledge. https://doi.org/10.4324/9781315456812

Welsh, M. (2014). Resilience and responsibility: Governing uncertainty in a complex world: Resilience and responsibility. *The Geographical Journal*, *180*(1), 15–26. https://doi.org/10.1111/geoj.12012

Wessells, M., & van Ommeren, M. (2008). Developing inter-agency guidelines on mental health and psychosocial support in emergency settings: *Intervention*, *6*(3), 199–218. https://doi.org/10.1097/WTF.0b013e328321e142

White, R., & Sashidaran, S. P. (2014). Reciprocity in global mental health policy. *Disability and the Global South*, *1*(2), 227–250.

Whitley, R. (2014). Beyond Critique: Rethinking Roles for the Anthropology of Mental Health. *Culture, Medicine, and Psychiatry*, *38*(3), 499–511. https://doi.org/10.1007/s11013-014-9382-y

Whyte, S. R. (2009). Epilogue. In L. Haram & C. B. Yamba (Eds.), *Dealing with uncertainty in contemporary African lives*.

Whyte, S. R., Geest, S. van der, & Hardon, A. (2002). *Social lives of medicines*. Cambridge University Press.

Whyte, S. R., Whyte, M. A., Meinert, L., & Kyaddondo, B. (2006). Treating AIDS: Dilemmas of Unequal Access in Uganda. In A. Petryna, A. Lakoff, & A. Kleinman (Eds.), *Global pharmaceuticals ethics, markets, practices* (pp. 240–262). Duke University Press.

Wiegratz, J., Martiniello, G., & Greco, E. (Eds.). (2018). *Uganda: The dynamics of neoliberal transformation*. Zed Books.

Wilhelm-Solomon, M. (2011). *Displacing AIDS: Therapeutic Transitions in Northern Uganda* [Oxford University]. https://doi.org/10.13140/RG.2.1.2647.6002

Wilhelm-Solomon, M. (2016). Disease as Dwelling: Sustaining Life with HIV in Post-displacement Northern Uganda. *African Studies*, *75*(3), 316–337. https://doi.org/10.1080/00020184.2016.1197665

Williams, L. (2021). Training Theories of Mind in Post-conflict Northern Uganda. *Medical Anthropology*, *40*(2), 196–207. https://doi.org/10.1080/01459740.2020.1802722

Williams, L. H. (2019). *In Search of a Stable World: Contamination of Spirits and Mental Disorder in Post-Conflict Northern Uganda*. Aarhus University.

Woodburn, U. (2009). IDPS And The Reconstruction Of Northern Uganda: Gender And Social Transformations In Gulu Town. In S. Marysse, S. Vandeginste, F. Reyntjens, & J. Stearns (Eds.), *L'Afrique Des Grands Lacs. Annuaire 2007-2008* (pp. 443–465).

World Bank. (2018). *Poverty Maps of Uganda Mapping the Spatial Distribution of Poor Households Based on Data from the 2012/13 Uganda National Household Survey and the 2014 National Housing and Population Census Technical Report*. World Bank. https://documents1.worldbank.org/curated/en/456801530034180435/pdf/Poverty-Maps-Report.pdf

World Bank. (2019). *Informing the Refugee Policy Response in Uganda—Results from the Uganda Refugee and Host Communities 2018 Household Survey*. https://documents1.worldbank.org/curated/en/571081569598919068/pdf/Informing-the-Refugee-Policy-Response-in-Uganda-Results-from-the-Uganda-Refugee-and-Host-Communities-2018-Household-Survey.pdf

World Bank. (2021). *Monitoring Social and Economic Impacts of COVID-19 on Refugees in Uganda—Findings from Round 3 of the High-Frequency Phone Survey* (p. 26). World Bank. http://hdl.handle.net/10986/35819

World Bank. (n.d.). *Prevalence of moderate or severe food insecurity in the population (%)*. World Bank Open Data. https://data.worldbank.org/indicator/SN.ITK.MSFI.ZS

World Bank. (2016). *An Assessment of Uganda's Progressive Approach to Refugee Management* [Working Paper]. World Bank. https://doi.org/10.1596/24736

World Food Programme (WFP). (2023, January 25). *WFP prioritises food assistance for the most vulnerable refugees in Uganda as needs outstrip resources | World Food Programme*. https://www.wfp.org/news/wfp-prioritises-food-assistance-most-vulnerable-refugees-uganda-needs-outstrip-resources

World Health Organization (WHO) (Ed.). (1977). *The selection of essential drugs*. WHO.

World Health Organization (WHO). (2001). *The World health report: 2001 : Mental health : new understanding, new hope*. World Health Organization. https://apps.who.int/iris/handle/10665/42390

World Health Organization (WHO). (2008). mhGAP: Mental Health Gap Action Programme: scaling up care for mental, neurological and substance use disorders. *Programme d'action Combler Les Lacunes En Santé Mentale (MhGAP) : Élargir l'accès Aux Soins Pour Lutter Contre Les Troubles Mentaux, Neurologiques et Liés à l'utilisation de Substances Psychoactives*, 36.

World Health Organization (WHO). (2011). The interagency emergency health kit 2011: Medicines and medical devices for 10,000 people for approximately 3 months. *Kit Sanitaire d'urgence Interinstitutions 2011 : Médicaments et Dispositifs Médicaux Pour Une Population*

de 10 000 Personnes Pendant Environ 3 Mois, *WHO/EMP/MAR/2011.3*. https://apps.who.int/iris/handle/10665/44663

World Health Organization (WHO). (2013a). *Building Back Better: Sustainable Mental Health Care after Emergencies*. WHO: Geneva. https://apps.who.int/iris/bitstream/handle/10665/96378/WHO_MSD_MER_13.1_eng.pdf?sequence=8

World Health Organization (WHO). (2013b). Mental health action plan 2013-2020. In *Plan d'action global pour la santé mentale 2013-2020*. World Health Organization. https://apps.who.int/iris/handle/10665/89966

World Health Organization (WHO). (2017a). *Policy options on mental health: A WHO-Gulbenkian mental health platform collaboration*. World Health Organization. https://apps.who.int/iris/handle/10665/259406

World Health Organization (WHO). (2017b). *The interagency health kit 2017: Medicines and medical devices for 10 000 people for approximately three months*. World Health Organization. https://apps.who.int/iris/handle/10665/279428

World Health Organization (WHO). (2020). *Mental Health Atlas 2020—Member State Profile—Uganda*. https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2020-country-profiles/uga.pdf?sfvrsn=c0fad0e9_6&download=true

World Health Organization (WHO). (2022). *World Mental Health Report*. World Health Organization.

World Health Organization (WHO), & United Nations High Commissioner for Refugees (UNHCR). (2015). *MhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies*. World Health Organization.

World Health Organization (WHO) & United Nations High Commissioner for Refugees (UNHCR). (2022). *mhGAP humanitarian intervention guide (mhGAP-HIG) training of health-care providers: Training manual*. World Health Organization. https://apps.who.int/iris/handle/10665/352581

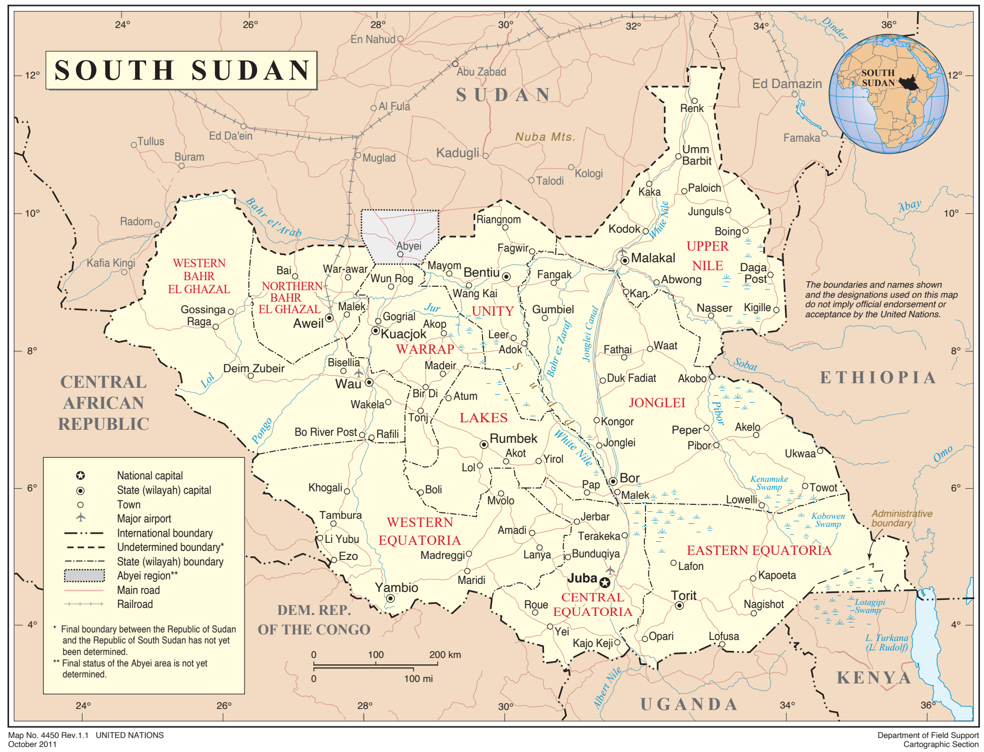
Yen, A. L. S. (2018). *The Life After Life: Pills, Peace, and Cen in Postwar Northern Uganda* [PhD Thesis, University of California, Davis]. https://www.proquest.com/docview/2091460048/abstract/CCEEA0FEBD554E5BPQ/1

Young, A. (1995). *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (First Edition). Princeton University Press.

Young, S., Wheeler, A. C., McCoy, S. I., & Weiser, S. D. (2014). A Review of the Role of Food Insecurity in Adherence to Care and Treatment Among Adult and Pediatric Populations Living with HIV and AIDS. *AIDS and Behavior*, *18*(5), 505–515. https://doi.org/10.1007/s10461-013-0547-4

Zetter, R. (n.d.). *Protection in Crisis: Forced Migration and Protection in a Global Era*. 37.

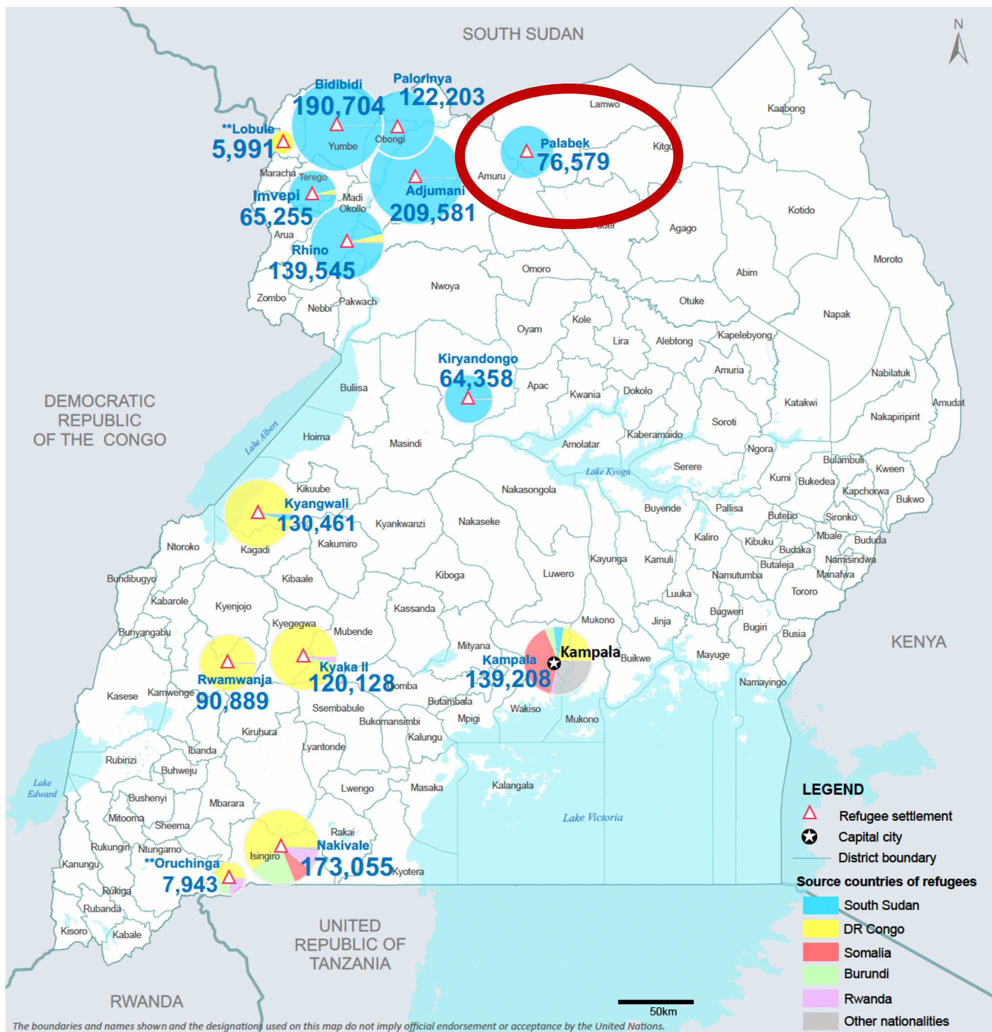
Appendix I. Maps



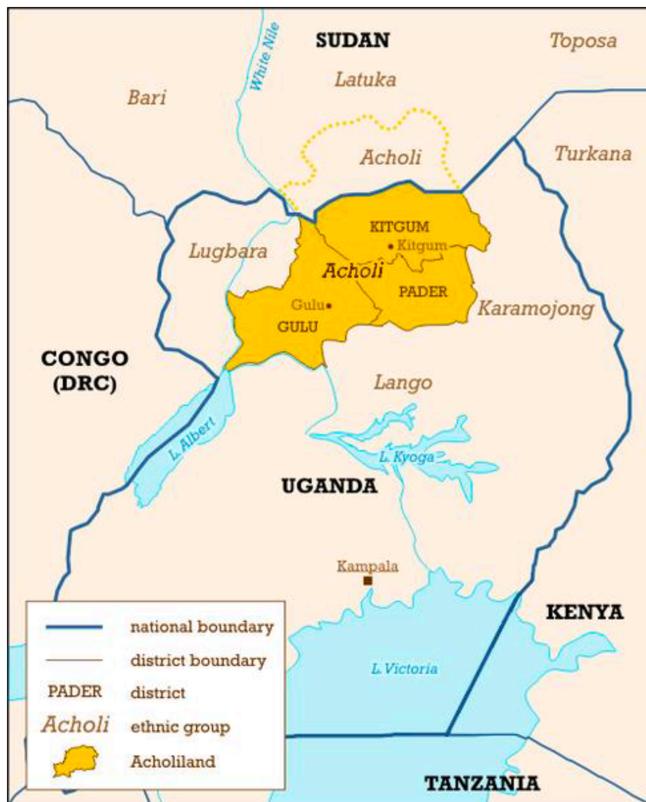
Map 1. Map of South Sudan. Source: UN Cartographic Section, Department of Field Support October 2011.

Map 2. Pajok in relation to both South Sudan and Uganda. Source: Google Maps.

Map 3. Lamwo District (in red), northern Uganda. Source: OpenStreetMap.



Map 4. Palabek (in red), in relation to other refugee settlements in Uganda. Source: UNHCR 2023.



Map 5. Distribution of Acholi-speaking people across the Uganda-South Sudan border. Source: Wikipedia.

Appendix 2. Additional contributions to the field

Self-help or silenced voices? An ethnographically informed warning

Wietse Tol and colleagues' study[1] in *The Lancet Global Health* describes the benefits of Self-Help Plus, a transdiagnostic psychological intervention aimed at stress reduction in humanitarian settings. Based on a randomised controlled trial in a refugee settlement in northern Uganda, their findings are impressive and benefit from extensive research. However, my ongoing, in-depth ethnographic research during the past 12 months in Palabek refugee settlement, northern Uganda, has identified crucial aspects that the study overlooks. In the psychosocial and socioeconomic context of South Sudanese refugees in northern Uganda, these factors should be taken into serious consideration.

Self-Help Plus is a multimedia guided intervention, based largely on a pre-recorded audio track that guides beneficiaries through exercises based on Acceptance and Commitment Therapy (eg, mindfulness and relaxation exercises).[2] Changes to the structure (eg, interventions from participants) are actively discouraged. The one-way nature of this approach is deeply problematic. In Uganda, scarcity and corruption-related mismanagement of UN funds often translate into scarcity of food and unfulfilled basic needs,[3] generating deep insecurity and feelings of powerlessness that South Sudanese refugees fleeing a brutal war have to navigate daily.

My ethnographic analysis shows that in this context, mental health interventions (eg, didactic counselling and cognitive behavioural treatments) have become outlets for beneficiaries to voice the very real problems that they are experiencing in daily life in the settlement. Most frequently, these are issues concerning scarcity of food, ineffective and inconsistent medical care at the health facilities, an absence of financial support to afford basic needs that fall outside of humanitarian aid (eg, soap and basic hygiene products or school supplies for children), and security concerns related to threatening living conditions in the settlement (including but not limited to domestic, sexual, and gender-based violence). Heavily scripted interventions like Self-Help Plus risk exacerbating the feeling of voicelessness and powerlessness that refugees are so accustomed to, silencing one of the few channels that people employ in an attempt to be seen and heard. Such interventions also risk shutting down the deeper political backdrop to their suffering.

Furthermore, our analysis reveals that stand-alone psychosocial support programmes are often interpreted by beneficiaries as active disengagement by humanitarian actors from issues and concerns that the refugees have clearly expressed to them. It must be better acknowledged that, in the face of the severe unfulfillment of basic needs, psychosocial interventions should meaningfully engage with refugees' concerns, not only by avoiding silencing them, but also by encouraging effective two-way communication that is embedded within a robust, interagency referral system.

I declare no competing interests.

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Costanza Torre
c.torre@lse.ac.uk

Department of International Development, London School of Economics and Political Science, London WC2A 2AE, UK

1 Tol WA, Leku MR, Lakin DP, et al. (2020). Guided self-help to reduce psychological distress in South Sudanese female refugees in Uganda: a cluster randomised trial. *Lancet Glob Health* 2020; **8:** e254–63.

2 Epping-Jordan JE, Harris R, Brown FL, et al. Self-Help Plus (SH+): a new WHO stress management package. *World Psychiatry* 2016; **15:** 295.

3 Green A. Uganda went from being a model of refugee response to a cautionary tale. Dec 10, 2018. https://www.worldpoliticsreview.com/insights/26946/with-its-open-door-policy-toward-refugees-uganda-has-gone-from-model-to-cautionary-tale (accessed Jan 31, 2020).